Chart No:

AUTHORIZATION FOR THE RELEASE/EXCHANGE OF INFORMATION

- I understand that my records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations and/or under state specific provisions.
- I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality, suicidality, and may contain confidential HIV (AIDS) related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

Patient Name: ___________________________ Date of Birth: _____________ SSN: _______________________

Address: _____________________________________City/State: _____________________ Zip: ______________

I authorize Cognitive Behavioral Specialists of the Tri-Cities to:

(*Please check the box, and initial the following which you are authorizing*): __________**Exchange with**
__________**Release to**
__________ **Obtain From**

Name: ____

Address: ____

Phone/Fax number: ____

I authorize the release/exchange of the following medical records and information (check all that apply):

All Materials in Records ❑ Medical History ❑ Psychosocial History ❑ Assessment and Diagnosis
❑ Attendance only ❑ Progress Notes ❑ Treatment Plans ❑ Substance Abuse Assessment
❑ Discharge Summary ❑ Summary of treatment ❑ Other:____

This information is required for (check one or more options):
❑ Summary of previous treatment ❑ Continuity of Care
❑ Insurance/managed care review (for justification of charges, quality of care, treatment progress, and/or medical necessity)

I understand that the information or records listed above will not be used for any purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited.

I understand that I may revoke this authorization at any time, unless action has already been taken on it, by giving written notice to the parties above.

This authorization will automatically <u>expire exactly one year</u> from the last updated signature below <u>for insurance releases</u>. This authorization will <u>expire exactly ninety days</u> from the date of the last updated signature below for all other releases.

Signature of Patient	Date	Signature of Witness/Staff	Date