ARISE BEHAVIORAL AND WELLNESS HEALTH
Psychiatric Medication Management

AUTHORIZATION FOR THE RELEASE/EXCHANGE OF INFORMATION

I understand that my records may be protected under the Federal confidentiality Regulations and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations and/ or under state specific provision. 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 Social Security Number

____ ____________________________ ___ _________________________

Street Address City State and Zip Code

I authorize ARISE BEHAVIORAL AND WELLNESS HEALTH to (please check one):

___Exchange with ___Release to ___Obtain from the third party I have indicated below:

1)**Name:**____

Relationship:______________________________

Address:____ City______________________ State__________ Zip__________

Phone:____ Fax #____

2)Name:____

Relationship:_______________________________

Address:____ City______________________ State__________ Zip__________

Phone:____ Fax #____

_____ **I authorize the release/exchange of ALL materials in medical records and information OR**

_____ **I authorize the release/ exchange of the following medical records and information (check all applicable)**

__ Assessment and diagnosis __Medical History __Psychosocial History

__Substance use and Assessment __Progress Notes __Treatment Plans

__Psychological Testing __Medication Records __ Attendance Only

__Only in an Emergency __Discharge Summary

__Other________________________________

This information is required for (check one or more options):

__Summary of Previous Treatment __Insurance/Managed Care Review __ Other_______________________

__Continuity of Care __Family/Support System Involvement

I understand that:

- The authorization will automatically expire one year from the date signed below, unless I indicate an earlier date: ____/____/______.
- This authorization is voluntary and I need not sign this form to ensure services.
- I have a right to revoke this authorization at any time by written notification to ReGenesis CAC.
- The revocation will not apply to information that has already been released in response to this authorization.

AUTHORIZATION FOR THE RELEASE/EXCHANGE OF INFORMATION, Cont.

- A photocopy of this form shall have the same force and effect as the original.

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 the parties other than those named above is prohibited. Furthermore, the records requested and all the copies of the information will be destroyed or returned before or immediately after the data listed below. 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 below.

Client's Signature:__________________________________ Date:________/__________/_________

Parent/Guardian Signature: ____________________________ Date:_______/__________/_________

Witness____ _ Date:_______/__________/_________

The person signing this authorization is entitled to a copy upon request.