Behavioral Health Network, Inc.

**AUTHORIZATION FOR THE INTERNAL EXCHANGE OF INFORMATION FOR INTEGRATED CARE**

**This form authorizes each program within Behavioral Health Network, Inc. (BHN) to exchange my Substance Use Disorder (SUD) Program Information with other BHN programs.**

**Print Client Name:**

| First | Middle | Last | DOB | Client ID |
|---|---|---|---|---|

In order to provide the best services and outcomes, BHN provides an integrated team approach in our work with you. Our approach takes into account your mental health, substance use, care management, care coordination, medical, social and economic needs that affect your health and well-being. This model is considered a best practice. To do this, we want to work with all your providers within BHN. This release authorizes BHN to provide you with Integrated Care.

**ACKNOWLEDGEMENT CONCERNING MY ALCOHOL AND DRUG TREATMENT RECORDS**

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 (Part 2 Regulations), and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160 and 164 (HIPAA Regulations), and cannot be exchanged within BHN without my signature below, unless the exchange is otherwise provided for in the Part 2 Regulations and the HIPAA Regulations.

**Please Initial Below:**

_____ I authorize each BHN program to exchange information, including my Substance Use Disorder (SUD) Program Records, with other BHN programs to provide Integrated Care from programs which I am receiving or have received services. I understand that this information will be shared on a need to know basis to assist in my current care and services.

_____ I understand that I have the right to limit the amount and type of information from my SUD Program Record that is exchanged within BHN. I also understand that any limitation I impose on the exchange of information within BHN may affect BHN's ability to provide integrated care on my behalf. I wish to limit the exchange of information from my substance use programs in the following way:

_____

**Start Date for Authorization**: _____ **End Date of Authorization**: _____

[End Date Cannot Be Greater Than 1 Year.]

**Additional Acknowledgements:**

- I understand that this Authorization will remain in effect until the expiration date identified above, or I provide a signed Authorization Revocation form to BHN in person or by mail to Medical Records, 417 Liberty Street, Springfield, MA 01104 at any time and for any reason. The revocation will be effective upon BHN's receipt of the signed Authorization Revocation form. The revocation will not have any effect on any action taken by BHN in reliance on this Authorization before BHN received my signed Authorization Revocation form.
- I understand that I may decline to sign this Authorization and that declining, or any revocation of this Authorization, may affect BHN's ability to provide integrated and coordinated care on my behalf.
- I understand that BHN is required to obtain a separate, signed authorization form from me in the event that BHN needs to release my SUD information to a program or provider that is not part of BHN.
- I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the exchange of my SUD information within BHN. By my signature below, I hereby, knowingly and voluntarily, authorize each BHN program to exchange my SUD information with other BHN programs in the manner described above.

_____ _____

Signature of Client/Patient/Individual Served Date

**If the individual has a Parent, Legal Guardian or Personal Representative, Provide the following signature:**

_____ _____ _____

Circle one: Parent/Guardian/Personal Representative Printed Name Here Date

Printed Name of Person Who Witnessed Signature (Not Required):

_____

**For Entities Receiving Records that may contain Substance Use Information**
**Prohibition on Re-disclosure of Confidential Information for Client in Alcohol or Drug Abuse Treatment**

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.