Authorization For Disclosure of Behavioral Health Treatment Information

I, _____ Date of Birth_____, authorize Salem Medical Clinic/Smithland Medical Clinic to disclose to and/or obtain the following initialed information to _____. The information obtained may be used or disclosed in connection with my mental health treatment, payment of services, or healthcare operations. I further understand that my provider will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization will impair coordination of care. Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by the authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, paper format or electronically. I understand that there is a potential that the protected health information that is disclosed pursuant to this authorization may be disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections.

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Salem Medical Clinic 141 Hospital Drive Salem, KY 42078 or Smithland Medical Clinic 205 E Adair Str. Smithland, KY 42081. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. This authorization expires on the following date unless revoked in writing sooner: _____

Please initial each item to be disclosed:

_____	Assessment	_____	Educational Information
_____	Diagnosis	_____	Discharge/Transfer Summary
_____	Psychosocial Evaluation	_____	Continuing Care Plan
_____	Psychological Evaluation	_____	Progress in Treatment
_____	Psychiatric Evaluation	_____	Demographic Information
_____	Treatment Plan or Summary	_____	Psychotherapy Notes
_____	Current Treatment Update	_____	Medication Management Information
_____	Presence/Participation in Treatment	_____	Nursing/Medical Information
_____	Other _____	_____	Other _____

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date

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