FORM # 1200B - Provider

Beaver County Behavioral Health
Authorization for Use or Disclosure of Protected Information

- I authorize _____ to use/disclose individual information as described below from the records of:

  Name: _____ 041#: _____

- This information identified below is being disclosed to:

  Name: _____

  For the purpose of:

  ☐Intake/Assessment ☒Coordination of Services ☒Case Management
  ☐Treatment Planning ☒At Individual's Request ☒Referral
  ☐Other (specify): _____

  Records being disclosed verbally and/or written:

  ☐Psychiatric/Psychological Evaluation ☐Benefit Program Application/Info ☐Progress Notes/Updates
  ☐IEP/School Info ☐Other Diagnostic Info ☐Discharge Information
  ☒Collateral Information ☐Medical/Social History ☐Treatment Plan
  ☐ Intake/Assessment ☐Individual Support Plan ☐Adaptive Behavior Assessment
  ☐Assessment Recommendations ☐Full Scale IQ ☐Medication Lists
  ☐Birth Records/Developmental History for period _____
  ☒Other (specify): Referral Form _____

- This Authorization will include disclosure of information relating mental health treatment, except psychotherapy notes.

- This Authorization may include disclosure of information relating to substance use and confidential HIV Related information **only if I place my initials on the appropriate line below.**
  I authorize the disclosure of my information to include: (indicate by initialing)

  Substance Use Information _____ HIV-Related Information _____

- This authorization is effective as of the date of the signature below and expires as indicated:

  Specific Date: _____ OR Event: _____

- I have been offered a copy of this form which I have:

  ☐Accepted ☐Declined

NAME: _____ 041#: _____

- I understand this authorization may be revoked in writing, or verbally if I am physically unable to revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance on this authorization.
- I understand Beaver County Behavioral Health will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this authorization.
- I understand I may inspect my personal mental health records prior to their release.
- I understand that my records are also currently protected under the Federal Privacy Regulations within the Health Insurance Portability and Accountability Act (HIPAA). 45 C.F.R. Parts 160 &164.
- Except with respect to records containing substance use, mental health, or HIV-related information, I understand that when the Information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and my no longer be protected by HIPAA or state confidentiality of records laws.
- I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Federal Law 42 CFR Part 2 also prohibits rediclosure of patient records without prior written consent.

_____ _____

Signature of Individual Date

**Signature of individual is required regardless of age when information contains drug/alcohol information or drug/alcohol diagnosis

**Individuals aged 14 and older control release of their mental health records when they understand the nature of the documents to be released and the purpose of releasing them.

_____ _____ _____ _____

Printed Name of Parent, Guardian, or Personal Representative | Relationship | Signature of Parent, Guardian, or Personal Representative | Date

If the individual has consented to the release of their mental health records, this authorization must also be signed by the staff member who obtained the individual's consent to release these records

_____ _____ _____

Printed Name of Witness #1 | Signature and Credentials of Witness #1 | Date

If completed via telehealth or if the individual consenting for their release is physically unable to provide a signature above, this authorization must be signed by an additional witness who observed that the person understood the nature of the authorization and freely gave their verbal consent.

☐Check if completed via telehealth

☐Check if physically unable to provide signature

_____ _____ _____

Printed Name of Witness #2 | Signature and Credentials of Witness #2 | Date