COMPASSIONATE BEHAVIORAL HEALTH

Authorization for Release of Protected Health Information

Pursuant to 45 CFR Pans 160 & 164 (HIPPA) & 42 CFR Part 2 (Drug & Alcohol Abuse Law)

Requesting records from: Name/Facility: _____ Address: _____ _____ Phone: _____ Fax: _____ Attention: _____	Send records to: Name/Facility: Address: Compassionate Behavioral Health 11670 Fountains Dr. Suite 200 Maple Grove, MN 55369 Phone 612-429-6714 Attention: Medical Records

DEMOGR

Patient Name:	Date of Birth:
SSN:	

INFORMATION REQUESTED

I hereby authorize the above-named provider to release the following confidential information to the person or entity name above: (Initial on lines provided in required)

IZ Physician/Provider's summary of diagnosis, medications, treatments, prognosis and recent care

Recent hospitalization Discharge Summary HIV/AIDS results

Mental Health Treatment Immunization History STD results [Z Substance Abuse Treatment C] Dental records All records [Z Other records (specify):

Purpose of disclosure: _____

CONSENT FOR RELEASE

I, or my authorized representative, request the disclosure of my protected health information as set forth on this form. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that:

1) The information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol and dmg abuse, or mental health treatment, only if I have placed my initials on the appropriate items listed above.
2) I understand that signing this authorization is voluntary. My treatment or payment for my will not be conditioned upon my authorization of this disclosure.
3) I have a right to revoke this authorization at any time by writing to the health care provider listed above, except to the extent information has been released in reliance upon this authorization.
4) I understand that information disclosed pursuant to the authorization may be re-disclosed by the recipient and no longer protected by the federal privacy regulations.

This authorization shall be valid and in effect until _____ or until two (2) years from date of execution, at which time this authorization expires.

All items on this form have been completed by me and all questions have been answered.

Patient Signature Date

Patient Printed Name

Witness Signature Date