COMMUNITY CARE BEHAVIORAL HEALTH ORGANIZATION
CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ to release information
(name of facility, agency, school, or person)
from the records of _____/_____/_____
(name of member) (DOB) (Med. Rec. #)
For the specific purpose of _____

METHOD OF RELEASE (must check one): ___ Verbal only ___ Copies only ___ Both
The information to be released is: (Please check all that apply) AND date/dates of service

	Psychiatric evaluation		**Psychological/Achievement Tests**
	Medical History		**Developmental History**
	Social History		**Academic/school records**
	Discharge summary		**Summary of Hospitalizations**
	Course of Treatment		**Treatment recommendations**
	Neurologicals		**Medication**
	Laboratory reports		**Other records: (specify)**
	Other:		

HIV-related information and drug and alcohol information contained in the parts of the record indicated above will be released through this consent unless otherwise indicated. ___ Do Not Release

Please forward information to the attention of:	**Facility/agency/person:**
	Address:
	Phone:

I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for 90 days after the date of my signature, unless specified below. I also understand that this consent is revocable, by contacting the Community Care Privacy Officer in writing, except to the extent that action has been taken in reliance thereon. We will not condition treatment, payment, enrollment in Community Care or eligibility for benefits on the person providing authorization for the requested use or disclosure. This consent shall be in effect from _____ until _____.

_____ _____
(Date of signature) **Signature of Patient (14 years of age or older)**

_____ _____
(Witness) **Signature of Parent/Legal Guardian/Authorized Representative**

I do __ do not __ want a copy of this release.

Prohibition of redisclosure:The information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general release of medical or other information is not sufficient for this purpose.

Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore, (1) Community Care and its employees have no responsibility or liability as a result of any re-disclosure and (2)such information would no longer be protected by the Privacy rule.

Oral Consent
(Not Applicable to HIV-Related Information)
For persons physically unable to provide a signature

I witnessed that the person understood the nature of this release and freely gave his/her oral consent.

Date of Signature:	**Signature of Witness:**
Date of Signature	**Signature of Witness:**