BEHAVIORAL HEALTHCARE OPTIONS, INC.

RELEASE OF INFORMATION FOR MENTAL HEALTH RECORDS

READ THIS INFORMATION FIRST: The purpose of this authorization is to grant Behavioral Healthcare Options, Inc. (BHO) permission to disclose your Mental Health records, including any pertinent Medical and School records, to the party identified below in this request. Once completed and signed, this authorization will remain in effect until the earliest of: (a) the date you specify below; (b) one year from date signed; or (c) the date you revoke it. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by the Federal privacy regulations. You may revoke this authorization in writing at any time, however it will not have any effect on any actions BHO took in reliance on the authorization. You may refuse to sign this authorization, and BHO does not require signature of this document in order to provide treatment services. Information pertaining to substance abuse diagnosis or treatment requires completion of the Consent for Release of Confidential Health Information under 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records.

PATIENT INFORMATION

Member Name (Parent/Guardian Name if Minor):			**Date of Birth:**
Street Address:	**Cell Phone:** ( )		**Home___ Work____ Phone:** ( )
P.O. Box:	**City:**	**State:**	**ZIP Code:**

INFORMATION TO BE DISCLOSED

The purpose of this authorization is: (check all that apply)

- ☒ To assist with evaluation and treatment
- ☒ On-going verbal communication for continuity of care and treatment
- ☒ Other (explain reason for authorization): **To comply with supervisory referral**

The information to be disclosed is: ☐ Medical History ☐ Diagnosis ☒ Progress Reports	☐ Social History ☒ Treatment Summary ☒ Other (Specify) **Attendance and compliance**

INFORMATION IS BEING SENT BY:

Name:	**Phone:**	**FAX:**
Address:	**City:**	**State:**
	ZIP Code:	

INFORMATION IS BEING SENT TO:

Name: Lauren Chirinos/Stephanie Glover Behavioral Healthcare Options, Inc.	**Phone: (800) 559-9749 FAX: (702) 242-5864**
Address: P.O. Box 36040	**City: Las Vegas** **State: NV** **ZIP Code:** 89113-6040

EXPIRATION (SELECT ONE)

This authorization will expire on (date):	☒ In one year	☐ Other (specify):

I acknowledge that the information to be disclosed was fully explained to me.

Member Signature: _____ Date: _____

BEHAVIORAL HEALTHCARE OPTIONS, INC.

Consent for the Release of Confidential Health Information under 42 C.F.R. PART 2 – Confidentiality of Alcohol and Drug Abuse Patient Records

I, _____
(Name of patient)

Authorize _____
(Name of provider, address, zip, phone, fax)

_____

_____

To disclose: **Treatment summary, progress reports, attendance and compliance**
(Kind and amount of information to be disclosed)

To: Lauren Chirinos or Stephanie Glover, Behavioral Healthcare Options, Inc.
P.O. Box 36040 Las Vegas, NV 89113-6040 Phone: (800) 559-9749 Fax: (702) 242-5864

For: **Compliance with supervisory referral**
(Purpose of disclosure)

I understand that my alcohol and/or drug abuse treatment records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent. I may revoke this consent orally or in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate upon: one year from date of signature below
(Specific date, event or condition)

Patient's Signature: _____ Date: _____
If the patient is a minor, only the minor can sign this consent.

_____ _____ _____
Print Name Date of Birth (MM/DD/YY) Medical Record Number

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: _____

Print: _____ Date: _____

Legal Authority: _____

NOTICE TO RECIPIENT OF INFORMATION

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

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sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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