Medical Centers
BEHAVIORAL HEALTH CLINIC

29 Medical Center Lane, Suite A Guntersville, AL 35976 Office: 256.571.8717 Fax: 256.571.8719

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ **D.O.B**:_____

1. **Authorization: (Please check one or both)**

_____ I authorize Medical Centers Behavioral Health Clinic to **OBTAIN** information from: **AND/OR** _____ I authorize Medical Centers Behavioral Health Clinic to **RELEASE** Information to:

Physician OR Name: _____**Location OR Relationship:** _____

Phone: _____ **Fax**: _____

2. Admit record; Diagnosis; History (Psychiatric Evaluation); Psychological; Social History; Educational Evaluation; Treatment Assessments and Plans; Progress Notes; Physical Exam; Lab and Consultation Reports; M.D. Orders; Discharge Summary; Radiology Reports, EKG

3. This may obtain acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV), behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire in 1 year.**

5. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the privacy officer at 256.894.6638.

6. The facility, its employees, officers, and physicians are hereby released from any legal responsibility of liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____ **Parent/Guardian:** _____
Witness: _____ **Date**: _____