Behavioral Health Release of Medical Information

Patient Name: ____ DOB: ____________________

Parent/Legal Guardian Name (if applicable): _________________ Relationship to patient: _________

I authorize The Family Connection to use and disclose the protected health information as indicated below:

- ❑ All health records related to drug/alcohol/substance abuse
- ❑ All health records related to emotional/mental/developmental disabilities/psychiatric conditions **(excludes psychotherapy notes)**
- ❑ Other: ____

Release of medical information from/to The Family Connection to/from:

Name: ____

Address: ____

Phone: ___________________________ Fax: ________________________________

I understand that this medical information may be used by the person I authorize for the purpose of medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I may cancel this authorization, in writing, at any time. I understand that my health care providers may have already released records according to this authorization prior to receiving my notice of cancellation. I understand that this will remain in effect until the end of treatment unless a date of expiration is indicated here: ________________

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that this information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ____________

Signature of patient or personal representative Date