



AUTHORIZATION FOR MUTUAL DISCLOSURE

Behavioral Connections of Wood County, Inc – PO Box 29, Bowling Green, OH 43402 (419) 352-5387

Client Name: _____ Date of Birth: _____ SS #: _____

I authorize information to be exchanged between **Behavioral Connections of Wood County, Inc.** and

 (Name of Authorized Organization/individual to whom disclosure is made) (Address &/or Phone)

The reason for this disclosure is:

- Coordination of treatment services Aftercare Planning Satisfy Legal Requirements Family Support/Involvement Billing/ Payment of Bill
 Other: _____

The specific information to be disclosed is: (check each specific item to be disclosed)

- | | |
|--|---|
| <input type="checkbox"/> Biopsychosocial/Diagnostic Assessments | <input type="checkbox"/> Treatment Plans/ Treatment summaries |
| <input type="checkbox"/> Recommendations/ Prognoses | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Legal History/ Probation/ Parole Information | <input type="checkbox"/> Treatment Dates |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Discharge Summary/ Continuing Care Plan |
| <input type="checkbox"/> Medication Sheets | <input type="checkbox"/> Psychological testing/assessment reports |
| <input type="checkbox"/> Medical History and Physical and Prior diagnosis | <input type="checkbox"/> Billing/Payment Information |
| <input type="checkbox"/> Lab/Diagnostic/TB tests/ Drug & alcohol testing results | <input type="checkbox"/> Other _____ |

I understand that the above items may include information regarding behavioral health treatment (mental health and/or substance abuse) that I may have received.

Amount of information to be disclosed: information covering all previous and current admission information covering current admission only
 information covering the previous 3 months specific dates: _____

This release will expire: 3 months 6 months 12 months, per client agreement other: _____ days/months after the date signed

- OR The specific date or event/condition upon which this consent will expire is _____
 OR The formal and effective termination or revocation of my probation, or parole, or other proceeding under which I was mandated into treatment
 (for court mandated substance abuse/dependency treatment)

The information released is for professional purposes only. Only the minimum amount of information needed to achieve the purpose may be disclosed. It may not be provided in whole or part to any other agency, organization or person, other than that which is stated above. I have read and agree that all information was properly completed prior to my signing this form, understand that this form is not required as a condition for treatment, and have the right to access the information to be disclosed. I have the right to shorten or lengthen the authorization period at any time. This authorization is **subject to revocation at any time** except to the extent that BCWC has already acted in reliance on it. The revocation must be in writing. I understand that BCWC cannot guarantee that the Recipient will not disclose my health information to a third party and the Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about alcohol or drug abuse treatment, the Recipient is prohibited from re-disclosure under federal law (42 CFR, Part 2) See notice below.

_____ (Client Signature)	_____/_____/_____ (date)	_____ (Parent / Guardian/Authorized Personal Representative Signature)	_____/_____/_____ (date)
_____ (Witness)	_____/_____/_____ (date)	_____ (Parent / Guardian/Authorized Personal Representative Printed Name)	

Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by Federal Confidentiality rules. 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 sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

Renewal of Expired Authorization:
 This authorization is renewed effective _____. The new expiration date is _____.
 Signature: _____
 Witness: _____

Revoked Authorization:
 Client/ Guardian has revoked this authorization as of _____ date
 Signature: _____
 Witness: _____