AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION- TPO

I, _____ , authorize Heritage Health Behavioral Services
(Client Name or Parent/guardian of client)

to Release To and Exchange With: (**CHECK all that apply**):

☐**My treating providers, health plans, third-party payers, and people helping operate this program**

☐_____
(Name(s) of Agency(ies) or Individual(s) or category of Agency(ies) or Individual(s)) (Address(es)) (Phone/Fax)

☐_____
(Name(s) of Agency(ies) or Individual(s) or category of Agency(ies) or Individual(s)) (Address(es)) (Phone/Fax)

the following information pertaining to _____
(Client Name) (Date of Birth)

(**CHECK all that apply**):

☐Medication Records
☐Case Management Plans
☐ Assessment
☐Treatment Plan
☐Psychiatric Evaluation
☐Admission/Discharge Summary
☐Drug Testing
☐History & Physical Exam
☐HIV/AIDS Related Information
☐Legal Services
☐Court Related Information
☐Progress/Status Reports
☐Other:_____

For the purpose of (**CHECK all that apply)**: ☐ Treatment, Payment, & Health Care Operations; ☐ Care Coordination; ☐Request of Client; ☐ Other:_____ (be as specific as possible)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that, after disclosure pursuant to this consent, my record, or information contained in my record, may be redisclosed in accordance with the permissions contained in the HIPAA Privacy Rule, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me, and that, in the event of such redisclosure, the disclosed record(s) will no longer be protected by 42 CFR Part 2. I understand that I may revoke this consent any time, by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: 365 days post discharge.

I also understand that this authorization is voluntary and that I may refuse to sign this authorization, however, my record(s) may not be disclosed if I refuse to sign this authorization. I understand that this agency may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

PLEASE FAX RECORDS REQUESTED TO:

☐ Heritage Health Therapy Services: CDA/PF/Rathdrum 208-667-7557 * ☐ Kellogg 208-784-5402
☐ Heritage Health Recovery Services: CDA 208-664-9217 * ☐ Kellogg 208-784-5402 * ☐ St Maries 208-245-4363
☐ Heritage Health Psychiatric and CCBHC Services 844-807-3782 * ☐ Neurobehavioral Services 208-292-6660

Each disclosure made pursuant to this consent must be accompanied by (1) a copy of this Authorization to Release/Exchange Confidential Information or a clear explanation of the scope of the consent; 2) 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.