

Consent to Release MH & SUD Records





Patient Information									
Patient Name:				Date of	Birth:	Pho	one:		
Address (City (Chats (7)))				Datas	/ / ()				
Address/City/State/Zip:					Dates of Treatment:				
				From:		To	<mark>)</mark> :		
				Program	Program(s) to Release: IP IOP PHP Med Mgmt Assessment Only				
Release Information from - Facility Name & Address: Beckett Springs 8614 Shepherd Farm Dr West Chester, OH 45069				Release Information to - Recipient Name & Address:					
Attn: HIM/Medical Records Department				Attn:					
Phone: 513-714-7368 Fax: 513-714-7375				Phone: () Fax: ()					
Email: 1101Beckett_him@lifepointhealth.net Email:									
How would you like to re	ceive your info	rmation:	Mail 🗆 Pick-up	□ Fax	☐ Encrypted Ema	ail (Provide reci	pient address/fax/e	email above)	
The Purpose Of Release:								_	
☐ Continuum of Care (CoC): Is this consent approved for the exchange of records between this facility & the recipient above? ☐ Yes ☐ No									
☐ Disability ☐ Financial ☐ Legal/Court ☐ Insurance ☐ Other Please specify:									
Information to be RELEASED I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. Please select information to be released by selecting Yes/No:									
Include Substance Use History/Treatment? ☐ Yes ☐ No Drug/Alcohol Test Results? ☐ Yes ☐ No									
Discharge Order?	☐ Yes ☐ No	Discharge Sun	nmary? 🗆 Ye	es 🗆 No	Discharge Plan?	☐ Yes ☐ No	Medications:	☐ Yes ☐ No	
Psychiatric Eval (CPE)?	☐ Yes ☐ No	History and Ph	nysical? 🗆 Yo	es 🗆 No	Labs?	☐ Yes ☐ No	Billing?	☐ Yes ☐ No	
MD/NP Progress Notes?	☐ Yes ☐ No	Treatment Pla	<mark>n</mark> ? □ Ye	es 🗆 No	Other:				
• Upon presentation to complete a request or pick up records, identification will requested to ensure validity/authority of the receiving party.									
In compliance with the HI release of substance use d (1) This consent is subje Revocation for ment verbally. (2) If not previously revoof this release unles (3) This authorization is from the provider. (4) If requested, the pat (5) I understand that my to a understand that the protected by the fede Patient/Legal Representative (If POA or Legal representative)	isorder treatme ct to revocation tal health recor oked, the patier s otherwise not in effect until the cient is entitled treatment, paym PHI used or dis ral Privacy Rules.	ent information at any time, ex ds must be pro nt's consent to r ted here: he expiration da to an accountin ent, enrollment, closed pursuant	(42 CFR Part 2), cept to the exterovided in writing release mental hate, event or cong of the disclosure ligibility for bento this authoriza	I acknowl nt that the g; revocati ealth and/ idition is n ures of the refits will no tion may b	edge the following facility has taken a con of substance under the facility has taken a con of substance abustance abustance and regardless are protected health of be conditioned o	g: action in relian se disorder re e information of whether the n information. n whether I sign	ce on the patient cords may be in will expire 90 day e patient is still re	e's prior consent. writing or given ys after the date ecciving services	
Witness Signature			Printed Name				// Date		
2nd Witness Signature (if verbal/telephone consent)			Printed Name						
Ziiu withess Signature (ii verbai/telephone consent)			Printed Name				Date		

Hospital Staff: Complete an Accounting of Disclosure each time you release records to outside entities. Record each release on form Record of Document of Disclosure (IP-W-066)

Verbal/Telephone Consent is hould be the exception in extenuating circumstances. Use of the Electronic form in Pulse should be used when feasible rather than verbal consent.

Verbal/Telephone Consent is NOT PERMITTED for patients treated for Substance Use; it is not allowed under 42 CFR part 2 Regulations, authorization must be written/e-signature.

NOTE TO RECEIVER This information has been disclosed to you from information protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The Federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.