Release/Obtain Now ____

Hold for Future Request____

The Mind & Body Consortium, LLC

Authorization for the Release of Confidential Information

I, ____ Date of birth: __________________________

Hereby authorize: Mind &Body Consortium to (check one or both) ________RELEASE TO or _________OBTAIN FROM

____

____

(PRINT NAME OF FACILITY OR INDIVIDUAL, ADDRESS, PHONE NUMBER/FAX NUMBER ON LINE ABOVE)

The information *specified* below (please *INITIAL* the information to be released/obtained):

_____Identifying information and presence in treatment
_____Psychological Testing Results and Report
_____Toxicology Results
_____Results of Diagnostic Studies
_____Treatment Plan
_____Medication Management Notes
_____Medications Prescribed
_____Insurance Benefits/Financial Information
_____Psychiatric Diagnostic Evaluation
_____Substance Use Disorder Assessment
_____Attendance in Treatment
_____Lab Results
_____Therapy Notes
_____Diagnosis
_____Treatment Summary and Recommendations
_____Billing Statement of Services Rendered

Correspondence to include: _____ Letters from MBC _____Phone messages _____Staff messages ______ Email messages

OTHER:____

Purpose for releasing/obtaining this information (please check all that apply): ___Case Management ___Treatment Planning __Service Coordination __Continuity of Treatment ___Consultation __Attorney/Legal/Court Matters ___Disability Determination

OTHER: ____

____

The undersigned understands that:

1. MBC is not conditioning treatment, enrollment, or eligibility for services on whether I agree to sign this authorization, except in limited certain circumstances.
2. I understand that my records are currently protected under the Federal Privacy regulations within the Health Insurance Portability and Accountability Act (HIPPA), 45 CFR, Parts 160, and 164. The information disclosed pursuant to this authorization may no longer be protected by Federal Health Privacy Rule and may be subjected to re-disclosure without my knowledge or consent or authorization.
3. I have the right to revoke this authorization orally or in writing at any time by contacting the Compliance Officer at 302.674.2380 or 156 S. State Street, Dover, DE 19901. I further understand that any revocation will be effective only to the extent that MBC has not already taken action in reliance on this authorization.
4. This information has been disclosed to the Requestor (MBC) from confidential records protected by State and Federal Statute. State regulations limit the Requestor's right to make further disclosure of this information without prior written consent of the person to whom it pertains.

I understand that my records may be protected under the Federal and State regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, Department of Health and Social Services, Policy Memorandum 5 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that this release automatically expires 30 days AFTER termination of service unless otherwise specified below. In addition, I release the above named organization / individual from all legal liabilities that may arise from this release.

This consent is given freely this _____________, 20____ (year) and will expire on ___________(not to exceed one year)

Authorizing Signature: ____ Date: ____________________

Relationship to Client: ____

Witness: ____ Date: ____________________

Effective: July 2018 Shared Drive/AdminAsst./OfficeDocuments