NE Behavioral Health
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Kirksville, Missouri 63501
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NORTHEAST MISSOURI HEALTH COUNCIL
"Partners for a *Lifetime* of health"

Authorization for the Release/Exchange of Information

☐ I understand that my records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations and/or under state specific provisions.

☐ I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality, suicidality, and may contain confidential HIV (AIDS) related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

Patient Name	Date of Birth	SS#
_____	_____	_____

Street Address	City	State	Zip
_____	_____	_____	_____

I authorize _____ to (please check and initial):

❑ Exchange with ❑ Release to ❑ Obtain from the party I have indicated below:

Name _____

Relationship _____

Address _____

City/State/Zip _____

Phone Number _____

I authorize the release/exchange of the following medical records and information (check all applicable):

❑ All materials in records
❑ Medical history
❑ Psychosocial history
❑ Assessment and diagnosis
❑ Progress notes
❑ Treatment plans
❑ Medication and treatment records
❑ Summary of psychological testing
❑ Discharge Summary
❑ Attendance only
❑ Only in an emergency
❑ Other: _____

(please complete reverse)

This information is required for (check all applicable):

- ❑ Summary of previous treatment
- ❑ Continuity of care
- ❑ Insurance or justification of charges, quality of care, treatment progress or medical necessity
- ❑ To keep patient's parent(s) aware of treatment
- ❑ Other: _____

☐ I understand that the information or records listed above will not be used for any purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited. Furthermore, the records requested and all copies of the information will be destroyed or returned before or immediately after the date listed below.

☐ I understand that I may revoke this authorization at any time, unless action has already been taken on it, by giving written notice to the parties below.

This authorization automatically expires, unless otherwise provided by state law, on (specific date): _____ *Recommended date is 6 months to no more than one year from date of signature below.*

_____ _____
Signature of Patient/Legal Guardian Date

_____
Relationship to Patient (if applicable)

_____ _____
Signature of Minor Patient Date

_____ _____
Signature of Witness/Requestor of Information Date

A copy of this form has been requested and received (initialed by patient): ___Yes ___No

FOR OFFICE USE ONLY:

DATE REQUEST FILLED: _____
BY:_____