



Balance Connection

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Authorization for Mental Health Care Information

I, _____ [Patient/Client], whose Date of Birth is ___ / ___ / _____

authorizes Balance Connection to disclose to and/or obtain from: (name of person, title or organization)

_____, located at:

(address) _____, City: _____, State: _____, Zip Code:

_____, the following information:

(mark all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Presence/Participation in Treatment |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Nursing/Medical Information |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Educational Information |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Medication Management Information | <input type="checkbox"/> Psychotherapy Note |

Other _____

For the purpose of: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Balance Connection at P.O. Box 538, Midway, UT 84049. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:

Conditions

I further understand that Balance Connection will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: (if any)

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections.

I request a copy of this form for my records: Yes _____ No _____

Signature of Patient/Client

Date

Signature of Parent, Guardian or Personal Representative

Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

Signature of Staff Witness

Date