Authorization for Exchange of Information

I hereby authorize Birchwood Behavioral Health to exchange personal health information between:
Birchwood Behavioral Health and ____ regarding:

Client: __________________________________
Date of Birth:____________________________

Please check specific information to be released:

- ▢ Verbal exchange of all information to aid in assessing and/or treating the client
- ▢ Clinical Summaries
- ▢ Continuing Care Plans
- ▢ Intake Assessments
- ▢ Psychiatric Reviews
- ▢ Psychological Evaluations
- ▢ Neuropsychological Evaluations
- ▢ Substance Abuse Assessments
- ▢ Clinical and Laboratory Results
- ▢ Discharge Summaries
- ▢ Immunization Records
- ▢ Medical History/Physical Exams
- ▢ Transcripts, Academic & School Behavior Records, Special Education Records
- ▢ Progress Notes
- ▢ Treatment Plans
- ▢ UA Results

This information may be used for the continuation of care. I understand that this authorization will expire 12 months from the date signed, with revocation of custodian/guardianship or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and/or facsimile copies of this authorization will be considered as valid as the original.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of this information to investigate or prosecute any alcohol or drug abuse patient. Disclosure of patient information is permitted with the patient's written consent: however, disclosures to central registries and in connection with criminal justice referrals must meet the following specific regulations (CFR 2.32 and 2.33). This information disseminated from Birchwood Behavioral Health.

I acknowledge that the information to be released is protected by federal law and may include information regarding drug/alcohol abuse, sexually transmitted diseases/HIV and/or Hepatitis B. My signature below authorizes the exchange of this information. I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that once the above information is disclosed, it may be subject to redisclosure by the recipient and no longer protected by federal privacy laws or regulations.

____________________________________ ____________________
Client Signature Date

_________________________________ _________________
Guardian Signature Date