First Name | Last Name | Case # | Site

760

Staff ID | Form Code | Service Date

3333 3333

ALL INFORMATION TO BE RELEASED **MUST** GO THROUGH THE **MEDICAL RECORDS DEPARTMENT.**

AUTHORIZATION & CONSENT FOR RELEASE OF MENTAL HEALTH INFORMATION

Client Name: _____

Date of Birth: _____, Social Security No.: _____

A. Authorization; Scope of Disclosure. I authorize Northwood Health Systems ("Northwood") and its agents and employees to disclose and release any and all confidential Mental Health Information relating to me to the following person(s) and/or organization(s):

Name of Persons and/or Organization(s): Address and Phone:

Disclosure of confidential mental health records to third-parties may result in the third-party not being subject to further federal and state laws governing the confidentiality of this information, which may no longer be protected.

B. Scope *of Authorization.* The scope of this Authorization and Consent shall be limited to the disclosure and release of Mental Health Information as hereinafter defined. Mental Health Information shall mean all information and records relating to any testing, assessment, evaluation, examination, diagnosis, prognosis, consultation, treatment or care I have received at Northwood, and all information and records contained in any client chart maintained on me, including any intake forms, client history forms, emergency service reports, office notes, progress notes, nurses notes, treatment plans, discharge summaries, laboratory data, test results and orders or reports of therapists, counselors, psychologists and psychiatrists, and the records of any other mental health or health care facility or provider contained in the chart(s) maintained on me. No authority is granted to release any *original* Mental Health Records.

C. Refusal Will Not Affect Right to Treatment. Pursuant to West Virginia Code section 23-7-2, I acknowledge and understand that refusal to give this Authorization and Consent will in no way jeopardize my right to obtain present or future treatment except where and to the extent disclosure is necessary for the substantiation of a claim for payment from a person other than me.

D. Specific Authority to Disclose Confidential Information. By authorizing Northwood to release Mental Health Information pertaining to me, I am specifically granting Northwood the authority to release and disclose any and all personal, private and confidential information with respect to me, including the following Confidential Information, if applicable:

1. Any information identifying me as an alcohol or drug abuser;
2. Information concerning any substance abuse and chemical dependency of mine, including any use and abuse by me of alcohol, illicit drugs, controlled substances and psychoactive substances for other than medicinal purposes;
3. Information concerning any diagnosis, prognosis or treatment which may be maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research conducted at Northwood, including detoxification and participation in a maintenance treatment program
4. The results of any drug test I have taken;
5. Any information relating to any genetic conditions or diseases, including sickle cell anemia;
6. Any information identifying me as a client of Northwood and a recipient of psychiatric treatment or other mental health services;
7. Any information transmitted by me or my family members for purposes relating to diagnosis or treatment of any physical, mental or emotional

condition I may have.
8. Any information transmitted by persons participating in the accomplishment of the objectives of diagnosis or treatment of any physical, mental or emotional condition;
9. Any diagnoses or opinions formed regarding my physical, mental or emotional condition;
10. Any advice, instructions or prescriptions issued in the course of diagnosis or treatment concerning any physical, mental or emotional condition;
11. The results of any psychological testing, evaluation, examination or assessment;
12. Information relating to any involuntary commitment proceedings, including examination results, findings of fact and case disposition;
13. The results of H IV-related tests or AIDS-related tests, if any, and any information concerning diagnosis, prognosis, care and treatment concerning H IV or AIDS; and
14. Any information relating to birth control, prenatal care, drug rehabilitation or related services, venereal disease or other sexually transmitted diseases.

E. Restrictions on certain uses and disclosures. I understand that I may request restrictions on certain uses and disclosures of treatment-related information by listing such restrictions in the space below.

_____

_____

_____

F. Consent to Disclosure. I willingly and voluntarily consent to Northwood's disclosure and release of all Mental Health Information and Confidential Information to the person(s) and/or organization(s) identified herein.

G. *Purpose of the Disclosure.* The Mental Health Information and records disclosed pursuant to this Authorization and Consent are disclosed only for the following purpose(s):

_____

_____

H. Further Disclosure Prohibited. Any Mental Health Information released hereby has been disclosed from records the confidentiality of which is protected by federal and/or state law. The persons and/or organizetions to which disclosure is made are prohibited from making any further disclosure or use of any Mental Health Information including information related to AIDS, HIV, and/or Substance Abuse without specific written consent of the undersigned unless further disclosure is otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I. Revocation. This Authorization and Consent is subject to revocation at any time except to the extent that Northwood has already taken action in reliance on it. If not previously revoked, this Authorization and Consent will terminate one year after the date it was signed or upon the date, event or condition noted below, whichever occurs first.

_____

J. *Effect of* Copy. A photocopy of this Authorization and Consent shall have the same force and effect, and may be relied upon, as if it were an original.

K. Approval By Legal Counsel. This Authorization and Consent has been approved by my legal counsel where given in connection with a legal proceeding.

L. Date Signed. I have been offered a copy of this Authorization and Consent.

_____
Date Signed

_____
Signature of Client or Legal Guardian**

_____
Signature of Witness

_____
Printed Name:

_____
Printed Name:

_____

***** If signature is the client's legal guardian or representative, then write the nature of your capacity with regard to authorization above.***