



AUTHORIZATION FOR RELEASE AND EXCHANGE OF CLIENT PROTECTED HEALTH INFORMATION

Full Name (Please Print) Client Number Date of Birth

Address

Phone Number AKA

I authorize the use and/or disclosure of my protected health information (PHI) contained in my clinical and billing records:

Between: MHS TBS San Bernardino and 790 Via Lata, Suite 300 Colton, CA 92324 (909)433-0445 Fax(909)433-0556

PHI includes health information created by Mental Health Systems, Inc. (MHS), health information collected from me, or health information received by MHS from another health care provider or health plan. PHI may relate to my past, present, or future physical or mental health condition. I understand that the information in my records authorized for disclosure may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

I understand that my alcohol and drug treatment records are protected by the Federal Regulations governing Substance Abuse Patient Records (42 CFR, Part 2) and HIPAA (45 CFR, 160 & 164) and cannot be released without my specific written authorization unless the disclosure is authorized by these regulations.

The disclosure of PHI authorized here is required for the following purpose: TBS coordination

The following information may be disclosed: (client must initial each box checked)

Grid of checkboxes for disclosure of information: Mental Health Evaluation, History & Physical Exam, Medication Records, Laboratory Results, Psychiatric Assessment, HIV/AIDS testing, Client Plan/Service Plan, Progress Notes, Physician Orders, Pharmacy Records, Diagnosis, Psychological Evaluation, Billing Records, Alcohol/Drug Treatment Records, Nursing Notes, Other (Provide Description)

Re-disclosure: I understand the MHS cannot guarantee the recipient of this information will not re-disclose my PHI to a third party. The recipient may not be subject to federal laws governing privacy of health information. California law generally prohibits recipients of my PHI from re-disclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this PHI is voluntary. I can refuse to sign this authorization; I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in Code of Federal Regulations (45 CFR, § 164.524).

I have a right to receive a copy of this authorization and would like a copy at this time.

Yes No

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

I agree that a photocopy or fax of this authorization will be as effective as the original.

Term: This Authorization will remain in effect:

- From the date of this authorization until _____, 200 .
- Until the following event occurs: _____.
- Date Authorization was revoked: _____.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly, and voluntarily, authorize MHS TBS San Bernadino to use or disclose my health information in the manner described above.

Signature of Client

Date

If the client is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal
Representative

Description of
Authority

Date