

Standard Authorization For Sharing of Medical and Mental Health Information

(Please return this to allie@dbteensnh.org)

I, _____ [Name of Client],

whose Date of Birth is _____, authorize DBTventies to disclose to and/or obtain from:

_____ [Name of Psychopharmacologist]

Psychopharmacologist's email: _____ Phone : _____

Mailing address: _____

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed)

Assessment Diagnosis Psychosocial Evaluation Psychological Evaluation
 Psychiatric Evaluation Treatment Plan or Summary Current Treatment Update
 Medication Management Information Presence/Participation in Treatment
 Nursing/Medical Information

Purpose

Educational Information Discharge/Transfer Summary Continuing Care Plan
 Progress in Treatment Demographic Information Psychotherapy Notes*
 Other _____ Other _____
(*Cannot be combined with any other disclosure)

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to DBTventies. 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 in 12 months.

continued...

Standard Authorization For Sharing of Medical and Mental Health Information (contd.)

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 more strict than HIPAA and provides additional privacy protections.

Signature of Patient/Client

Date