HORIZON
www.horizonbh.org

If this form is submitted as part of a request for health information, allow up to 30 days from date of receipt.

Authorization to Disclose/Receive Protected Health Information

Mail/Return to: Horizon Behavioral Health, HIM Dept. 2215 Langhorne Rd. Lynchburg, VA 24501

For more information about this form contact the Health Information Department at 434-948-4883 or fax 434-846-0427

NAME OF CLIENT:

Name of: ☐ Parent, ☐ Legal Guardian, or ☐ Authorized Representative for an Adult:

DOB: | **HBH ID #:**

This authorization **Expires**
on: _____
mm / dd / yy

I authorize Horizon Behavioral Health to exchange protected health information with:

Name of Person and Organization:	Address:	Phone:	Fax:

The following information:(Check all that apply)

☐ Entire Medical Record ☐ Transportation / Accessibility Needs ☐ Financial / Billing ☐ Admission/Assessment ☐ Progress Notes ☐ Service Plan ☐ Diagnosis ☐ Lab Results ☐ History and Physical Report ☐ Psychiatric Evaluations ☐ Psychological Testing/Reports ☐ Discharge Summary ☐ Medication information ☐ Medical Information / Reports ☐ Dates and Types of Services Received ☐ **HIV+, AIDS** information / status ☐ **HBV, HCV** information / status ☐ Scheduling/Canceling appts.

Substance use options: (diagnosis may be on all documents) ☐ None ☐ All substance use information ☐ Drug screens ☐ Substance Use Outpatient ☐ Substance Use Screening and Referral Info. ☐ Substance Use history ☐ Substance Use Treatment plans ☐ Substance Use Assessments ☐ Residential Treatment (Detox) ☐ Other

_____

PURPOSE*:* I understand that this information will be used for the following: (Check all that apply)

☐ Evaluation / Treatment ☐ Legal Purposes ☐ Insurance / Billing Purposes ☐ Other (specify) _____

As the person signing this Authorization form, I understand that I am giving my permission to **Horizon Behavioral Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above. **And, I understand that:**

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.

B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.

C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.

D. Information disclosed under this authorization may be subject to **redisclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.

F. This authorization is automatically revoked upon termination of services or **one year from the effective date** of the authorization, whichever comes first. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 C.F.R. limits those who may act in the place of a client who has been adjudicated mentally incompetent to individuals who have been appointed the client's legal guardian. 42 C.F.R. permits limited disclosures about deceased clients when required by federal or state laws for the collection of vital statistics or an investigation into the cause of death. Any other disclosure of information identifying a deceased client as an alcohol or drug abuser is subject to the 42 C.F.R.

Signature of Individual Served: Date: / /
(The signature of the minor is required for release of substance use information)

Signature of: ☐ Parent, ☐ Legal Guardian, or
☐ **A**uthorized **R**epresentative for an Adult: Date: / /

Signature of Witness (if applicable): Date: / /

REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME): **Relationship:**

Signature of Person Revoking Authorization: Date: / /