ADVANCED BEHAVIORAL HEALTH, INC.
Behavioral Health Recovery Program Eastern Region Service Center
Intensive Case Management Programs

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
THIS IS A LEGAL DOCUMENT AND WILL NOT BE HONORED UNLESS IT IS COMPLETED IN FULL

PATIENT/CLIENT (Last Name, First Name) _____ Date of Birth _____ EMS ID Number _____ Last 4 digits of SSN# _____

Provider Name: _____

I, the undersigned, authorize the above name facility to ☐ DISCLOSE information to ☐ OBTAIN information from ABH ☐ Behavioral Health Recovery Program's Intensive Case Mgmt ☐ Eastern Region Service Center Case Mgmt program
I understand that this authorization is voluntary and that information to be released/obtained may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified:

Limitations/Restrictions: _____

Purpose of Release: (Check appropriates boxes)
☐ Case Management Coordination ☐ Placement/Referral
☐ Other (specify): _____

Information to be released/obtained: (check appropriate boxes)
☐ Psychiatric Evaluation ☐ Medical History and Physical Exam ☐ Treatment Plans
☐ Psychosocial History/Assessment ☐ Psychological Evaluation ☐ Medication Records
☐ Diagnostic Reports (specify): _____
☐ Other (specify): _____

Dates of Treatment Covered by this Request:	This authorization, if not cancelled, will expire:
☐ All prior episodes of care, through discharge from present episode of care ☐ Limited to the following Date(s):	Date (not to exceed 12 months), event or condition upon which the authorization expires. If blank, authorization will expire 12 months from date of signature below.

I understand that refusal to sign this authorization form will in no way affect my right to obtain present and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by signing the "Cancellation/Revocation" section below, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of psychiatric, substance abuse and HIV/AIDS records are protected under State and Federal Laws and cannot be disclosed without my written authorization unless otherwise provided for by law. The information disclosed by this facility pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law. I understand that this authorization is voluntary and that information to be released may include Medical, Psychiatric, Substance Abuse and/or HIV/AIDS treatment information unless otherwise specified above.

_____ _____
Signature of Patient/Client/Authorized (Legal) Representative Date

A copy of this authorization will be provided to the Patient/Client/Authorized Representative as requested.

CANCELLATION/REVOCATION: _____ _____
Signature of Patient/Client/Authorized(Legal) Representative* Date

*If this form has been signed by the patient's/client's Authorized (Legal) Representative, a copy of the legal appointment must be attached.

NOTE: Confidentiality of psychiatric, drug and/or substance abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Conn. General Statutes, Chapters 899c and 368x and Federal Regulations 42CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for release is NOT sufficient for this purpose.