COASTAL
BEHAVIORAL
SCIENCES

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Release of Confidential Patient Information
&
Authorization for Coastal Behavioral Sciences (CBS) to Use & Disclose confidential Patient Health Information

Patient Name: _____ **Patient DOB:** _____ / _____ / _____

I. Authorization:

The Providers at Coastal Behavioral Sciences may use, exchange or disclose the following health care information, in written, electronic, faxed or oral form, *please initial boxes next to information that can be released:*

	Clinical/Psychiatric Initial Assessment		Medical History/Medication Management
	Service Notes/Content of therapy sessions		Treatment Plan
	Clinical Impressions		Alcohol/Drug Treatment Information*
	Psychological Evaluation		Other: _____

☐ My health information for the following dates only: _____

II. Authorized Parties:

The Providers at Coastal Behavioral Sciences (listed above) may use, exchange or disclose my above authorized health care information, in written, faxed or oral form with:

Name, address, phone & fax number, if available, of provider/organization/individual:

_____
_____
_____

III. Reason(s) for Release of Information:

- o At my request to coordinate ongoing treatment with my other health care providers
- o At my request to supply my medical records to: _____
- o Other: _____

IV. My Rights:

I understand that I do not have to sign this authorization for release of information in order to receive treatment at Coastal Behavioral Sciences, unless my provider(s) at CBS feel that without such information, they cannot safely and legally offer me mental health care. *I understand that I may revoke this authorization at any time by submitting such a request for revocation in writing, though this revocation will not apply to information already disclosed prior to the revocation. If not revoked, this release will automatically expire 1 year from the date signed or the following date: ___/___/____.*

I understand that the providers at CBS are not responsible for how my health care information is used once it is released from their office per my request. I hereby release each and every provider and staff person at Coastal Behavioral Sciences from any and all liability that may arise from the release of my confidential healthcare information for its specified purpose. This release is, to the best of my knowledge and the knowledge of the staff and providers at CBS, to be HIPAA compliant. I understand and acknowledge that this authorization may consent for release of alcohol/drug abuse and mental health information.

*Person served must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2. Confidential information relative to a client with Substance abuse, HIV infection, AIDS, or AIDS related conditions shall only be released in accordance with G.S. 130A-143. A clear and legible photocopy of this authorization to disclose Protected Health Information shall be considered to be as valid as the original.

_____ _____
Signature of Patient/Printed Name Date signed and accepted

_____ _____
Signature of Patient's Legal Guardian/Printed Name Date signed and accepted

_____
Witness Signature/Printed Name