BUTLER BEHAVIORAL HEALTH SERVICES, INC.
AUTHORIZATION TO RELEASE/RECEIVE PERSONAL HEALTH INFORMATION

Any and all programs/departments of ***Butler Behavioral Health Services*** are authorized to receive/disclose information according to the following:

I hereby authorize ***Butler Behavioral Health Services*** and the person/organization identified below to: ☐ send ☐ receive

☐ my protected health information ☐ protected health information about my son/daughter/child in my custody/person of guardianship

Specific Identification of Person or Entity Authorized to exchange information with *Butler Behavioral Health Services*:

Name: Organization:

Address: City: State: Zip Code:

Phone: Fax: (if HIPAA covered entitiy):

I authorize the following information to be released:

☐ Diagnosis ☐ Attendance Reports ☐ Progress Notes ☐ Crisis Assessment/Plan
☐ Closing Summary ☐ Telephone Consultation ☐ Treatment Recommendation ☐ Labs and Medical information
☐ Psychiatric Evaluation ☐ Diagnostic Evaluation ☐ Treatment Plan ☐ Other

This authorization includes release of records relating to ("X" appropriate boxes):

☐ Diagnosis and /or treatment for alcohol and/or drug abuse ☐ HIV test results
☐ AIDS/AIDS Related Complex (ARC) diagnosis and/or treatment ☐ Diagnosis and/or treatment relating to other communicable diseases

Indicate here any additional exceptions, restrictions or exclusions, if any, to information released.

Name of person completing form: _____

This authorization for use/disclosure is for the following purpose.

☑ Case Collaboration ☐ Legal Matters ☐ Social Security Disability Claim ☐ Other: (specify) _____

This authorization will remain effective **until the end of treatment** unless an earlier date or condition/event is specified here _____. However, I that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that either party has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

BBHS Name and Address	Print Name
Butler Behavioral Health Services **1490 University Blvd, Hamilton, Ohio 45011**	**Medical Records Fax:** **513-881-7182**

Print Name of Client:	Date of Birth	Social Security #	
Signature of Individual/Guardian/Personal Representative		Date Signed	Date of Expiration

If this information has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

☐ Parent/Guardian ☐ Other: (specify)_____

Print to PDF and Clear Form

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by State and Federal law. ORC 5122.31, 45 CFR Part 2, and/or ORC 3701.243 prohibit you from making any further disclosure of it without specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose. Your rights to privacy are fully described in the brochure "BBHS Privacy Notification."