BIO-BEHAVIORAL MEDICAL CLINICS, INC.

Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Date of Request: _____

Patient Initial

_____ Patient request records to be faxed to another facility or physician's office. Patient is aware of confidentiality risks involved and releases BBMC, Inc., from responsibility for this fax. **FAX Number** _____

_____ It is the policy of Bio-Behavioral Medical Clinics, Inc. to not release records directly to the patient.

_____ In order to improve continuity of care, your health plan recommends that we forward a copy of the Initial Evaluation to your primary care physician.

Name of Physician and/or Firm Receiving Information

Name: _____

Address: _____

_____

The information supplied is to be restricted to:

☐ Diagnosis ☐ Medical Record ☐ History & Physical ☐ Lab Work

☐ Progress Notes ☐ Assessment ☐ Other: _____

Bio-Behavioral Medical Clinics, Inc. and/or administrative and clinical staff are hereby authorized to disclose Protected Health Information (PHI) to the above named physician or firm. This authorization includes the release of records with documentation of treatment or follow-up care, pertaining to mental health, alcohol and/or drug abuse or overdose, if applicable, with the categories specified above.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to this office at 1060 W. Sierra Avenue, Suite 105, Fresno, CA 93711. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. My physician or therapist will not condition my treatment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating (PHI) for disclosure to a third party.

I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations, however, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that Bio-Behavioral Medical Clinics, Inc. and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy law or regulations. Bio-Behavioral Medical Clinics, Inc. will not be held responsible for any subsequent disclosure by the recipient of health information. I release BBMC, Inc. and its employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

If this release is signed by someone other than the patient/client (i.e. Parent, Guardian or Legal Representative), state your name and legal relationship to the patient/client:

Signature _____ Name of Parent, Guardian or Legal Representative _____

Date Signed _____

State relationship and authority to sign on behalf of the patient: _____

BBMC, Inc. will process the request and release PHI (records) within 12 working days from the date of request.

REVOCATION OF THIS AUTHORIZATION

(Only sign this area if you wish to revoke authorization that is already in place)

I hereby revoke this Authorization for Disclosure of Protected Health Information (PHI)

Signature _____ Name of Parent, Guardian or Legal Representative _____

Date Signed _____

State relationship and authority to sign on behalf of the patient: _____