

## Authorization to Release Medical, Mental Health and Substance Abuse Information

Upon presentation to pick up information or complete an authorization a request for identification will be made to ensure validity/authority of the receiving party.  In compliance with all state confidentiality/privacy statutes/regulations regarding the release of mental health information and federal confidentiality rules in 42 CFR Part 2 regarding release of substance abuse treatment information:  1. This authorization is subject to revocation at any time. Revocation can be given orally or in writing.  2. If not previously revoked, the patient's consent to release mental health and/or substance abuse information will expire 90 days (3 months) after the date of this release unless otherwise noted here:  3. This authorization is in effect until the expiration date, event or condition is met and regardless of whether the patient is still receiving services from the provider.  4. If requested, the patient is entitled to an accounting of the disclosures of their protected health information.  5. My treatment, payment, enrollment, eligibility for benefits will not be conditioned on whether I sign this authorization.  Patient's signature: [includes minors 16 years]  Parent/legal guardian's signature: POA or legal representative, please provide copy of legal documents  Bate:  Time:  NOTE TO RECEIVER: The information that is being disclosed is confidential and protected by federal law. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations, including HIPAA and 42 CFR, Part 2, which prohibits the receiver of this information from making any further disclosure of same, except with the written authorization of the person to whom it pertains. A GENERAL AUTHORIZATION for the release of medical/psychiatric normation is not sufficient for this purpose. Federal laws and regulations restrict any use of the information to investigate	Patient name:Date of birth:/Phone:				
Please release requested information TO/FROM:    Please release requested information TO/FROM:	Address/city/state/ZIP:	Program: □Inpatient □PHP □IOP			
Attn.:  Attn.:  Phone:  Phone: 713-795-8899  Fax:  Fax: 713-795-8896  Ligve my authorization for SUN Behavioral staff to speak with treatment and/or benefits/financial information.  Dates of Treatment being requested:  The recipient of the information released may use it only for the following purposes (must be indicated): Continuum of care   Disability   Insurance   Legal purpose/court   School/educational needs   Military   Other - please specify:   Information to be RELEASED: I authorize SUN Behavioral to release and discuss medical records including (any information releated to medical, surgical, psychological, social, psychietric, drug and/or alcohol abuse, diagnosis, treatment, prognosis and/or the rapp of thereir contained. INITIAL:   The information authorized for release may include information available or veneral diseases, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome. INITIAL:   The Information authorized for release may include information authorized for pleases may include information authorized for pleases may include information authorized for pleases may include information authorized for please may include information authorized for please may include information authorized for pleases may include information and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome. INITIAL:   The Information authorized for pleases property   Institute psychiatric evaluation   History & physical   Orders   Labs   Discharge paperwork   Medication information   History & physical   Orders   Labs   Discharge paperwork   Medication information   Benefits/financial   Orders   Labs   Discharge paperwork   Medication information   Benefits/financial   Orders   Labs   Labs   Discharge paperwork   Medication information   Discharge paperwork   Medication information   Discharge paperwork   Medication information   Discharge paperwork   Medication informatio	Please release requested information TO/FROM:	Please release requested information TO/FROM:			
Phone: 713-795-8859  Fax: Fax: 713-795-8896  I give my authorization for SUN Behavioral staff to speak with reatment and/or benefits/financial information.  Dates of Treatment being requested:  The recipient of the information released may use it only for the following purposes (must be indicated):  Continuum of care Disability Insurance Legal purposes (must be indicated):  Continuum of care Military Other-please specify:  Information to be <u>RELEASED</u> : I authorize SUN Behavioral to release and discuss medical records including (any information releated to medical, surgical, psychological, social, psychilatric, drug and/or alcohol abuse, diagnosis, treatment, prognosis and/or therapy) therein contained. INITIAL:  The information authorized for release may include information about communicable or venereal diseases, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome. INITIAL:  Discharge summary Initial psychiatric evaluation History & physical Orders Labs  Discharge paperwork Medication information Benefits/financial  Other - please specify:  How would you like to receive your information? Mail Pick-up, Fax Email:  • Upon presentation to pick up information or complete an authorization a request for identification will be made to ensure validity/authority of the receiving party.  In compliance with all state confidentiality/privacy statutes/regulations regarding the release of mental health information and ederal confidentiality rules in 42 CFR Part 2 regarding release of substance abuse treatment information.  1 This authorization is subject to revocation at any time. Revocation can be given orally or in writing.  2 If not previously revoked, the patient's consent to release mental health and/or substance abuse information will expire 90 days (3 months) after the date of this release unless otherwise noted here:  3. This authorization is ineffect until the expiration date, event or con		7601 Fannin St.			
Fax: 713-795-8896  Igive my authorization for SUN Behavioral staff to speak with reatment and/or benefits/financial information.  Dates of Treatment being requested:  The recipient of the information released may use it only for the following purposes (must be indicated):  Continuum of care Disability Insurance Legal purpose/court School/educational needs Military Dother - please specify:  Information to be RELEASED: 1 authorize SUN Behavioral to release and discuss medical records including (any information releated to medical, surgical, psychiological, social, psychiatric, drug and/or alcohol abuse, diagnosis, treatment, prognosis and/or therapy) therein contained. INITIAL: The information authorized for release may include information about communicable or venereal diseases, which may include, but are not limited to, diseases such a Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome. INITIAL:  Discharge paperwork Initial psychiatric evaluation History & physical Orders Labs Discharge paperwork Medication information Benefits/financial Orders Labs Other - please specify:  Upon presentation to pick up information? Mail Pick-up Fax Email:  Upon presentation to pick up information or complete an authorization are request for identification will be made to ensure violatify/authority of the receiving party.  In compliance with all state confidentiality/privacy statutes/regulations regarding the release of mental health information and ederal confidentiality rules in 42 CFR Part 2 regarding release of substance abuse treatment information:  This authorization is subject to revocation at any time. Revocation can be given or rally or in writing.  In other proviously revoked, the patient's consent to release mental health and/or substance abuse information will expire 90 days (3 months) after the date of this release unless otherwise noted here:  This authorization is in effect until the expiration date, event or condition is met and regardless of wh	Attn.:	Attn.:			
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