



# ROCHESTER CENTER FOR BEHAVIORAL MEDICINE

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## Consent for "Releasing" or "Obtaining" Confidential Medical Information

PLEASE READ THIS FORM THOROUGHLY PRIOR TO COMPLETING IT IN ITS' ENTIRETY.

Patients Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Patient's S.S. # \_\_\_\_\_

I hereby freely and voluntarily authorize Party Releasing Records to:

- Verbally release/disclose my protected health information
- Physically release my records

Physician/Organization/Person  
Releasing Records:

Physician/Organization/Person  
Receiving Records:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax #: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax #: \_\_\_\_\_

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. It may also include information about behavioral or mental health services (Code 42 of Regulations, Part 2). I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice (Facility Name) Privacy Officer, except to the extent that action has already been taken in reliance on it. If not previously revoked by me in writing, this authorization is effective on this date and will expire one (1) year following discharge from treatment.

Information to be used or disclosed:

- Psychological Intake     Progress Report     Treatment Plan     Complete Records     Diagnosis     Psychological Screening  
 Other (explain) \_\_\_\_\_

Purpose of disclosure:

- Insurance Matters     Academic Matters     Legal Matters     Patient Request     Progress Updates     Referral for Services  
 Coordination of Care (between RCBM & another provider)     Continuation of Care (continuation of psychiatric care with a new provider)  
 Other (explain) \_\_\_\_\_

\_\_\_\_\_  
Patient or Parent/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed By

\_\_\_\_\_  
Date