

RiverValley Behavioral Health, Inc. and affiliates:

Acumen Counseling Services
CigarFactory Complex
Behavioral Healthcare Services

Henderson Group Home

RiverValley Consulting Services, Inc.
Independent Living III
Independent Living II

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

(****ALL SECTIONS MUST BE COMPLETED****)

The undersigned hereby authorizes the use or disclosure of information from the medical record of:

1. Client Name: _____ Social Security Number _____ (optional)
Date of Birth: _____ Health Record ID# _____ (optional)

2. FROM (PERSON/AGENCY PROVIDING INFO) TO (PERSON/AGENCY RECEIVING INFO)

- FROM (PERSON/AGENCY PROVIDING INFO) TO (PERSON/AGENCY RECEIVING INFO)

3. TYPE OF INFORMATION TO BE USED OR DISCLOSED

____ • Psychiatric Evaluation
____ • History/psychosocial
____ • Treatment Progress
____ • Testing
____ • Other

____ • Medical/physical history
____ • Labs & Radiology results
____ • Staff notes (not including
Therapist Notes)

____ • Admission/Intake
____ • Medication History
____ • Discharge/Termination
Summary

4. I am requesting records from the following time period:

5. RELEASE OF SPECIAL RECORDS (THIS SECTION MUST BE COMPLETED)

I authorize the release of information pertaining to:

- a. The diagnosis or treatment of **HIV/AIDS, including test results**
b. **Drug and/or alcohol treatment records***

YES NO/NA
 YES NO/NA

* Alcohol and/or drug treatment records are protected under federal regulations governing the confidentiality of alcohol and drug abuse patients records, 42 CFR Part 2, and the Health Insurance Portability and Accessibility Act, 45 CFR Parts 160 and 164. These rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

6. PURPOSE FOR USE OR DISCLOSURE

7. I understand I have the right to revoke this authorization at anytime in writing and upon delivery to RiverValley or one of its affiliates ("RiverValley") except to the extent that action has been taken in reliance on this authorization, or if applicable, during an insurance contestability period. Unless another date/event/condition is specified, this release will expire one year from the date it is signed.

Date/event/condition: _____

8. I understand: 1) generally, RiverValley may not condition my treatment on whether I sign a consent form but in certain limited circumstances I may be denied treatment if I do not sign a consent form; 2) I will be given a copy of this form if I ask; 3) RiverValley cannot ensure the above records will not be redisclosed by the party who receives them; and 4) RiverValley has 30 days to respond to a request for access to my records unless I am notified by mail that my request cannot be processed within that time.

Signature of Patient _____

/Date

Signature of: Parent Guardian Other _____/Date

• **WITNESS: I know the person signing this form or am satisfied of this person's identity.**

Signature of Witness: _____