Premier Care
Behavioral Health

Authorization for Disclosure of Mental Health Treatment Information

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I, _____ [Name], authorize Premier Care Behavioral health to disclose to and/or obtain from: _____ the following information:

Description of Information to be Disclosed.

_____ Assessment	_____ Presence/Participation in Treatment
_____ Diagnosis	_____ Discharge/Transfer Summary
_____ Psychosocial Evaluation	_____ Continuing Care Plan
_____ Psychological Evaluation	_____ Progress in Treatment
_____ Psychiatric Evaluation	_____ Demographic Information
_____ Treatment Plan or Summary	_____ Psychotherapy Notes
_____ Current Treatment Update	_____ Other_____
_____ Medication Management Information	_____ Other_____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Premier Care Behavioral Health. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Conditions: I further understand that Premier Care Behavioral Health will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we dseem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____ _____

Printed Name of Patient **Date of Birth**

_____ _____

Signature of Patient/Legal Representative **Date**

_____Check here if patient/client refuses to sign authorization