

The Mind & Body Consortium, LLC

Authorization for the Release of Confidential Information

I, _____ Date of birth: _____

Hereby authorize: Mind &Body Consortium to (check one or both) _____ RELEASE TO or _____ OBTAIN FROM

(PRINT NAME OF FACILITY OR INDIVIDUAL, ADDRESS, PHONE NUMBER/FAX NUMBER ON LINE ABOVE)

The information specified below (please initial the information to be released/obtained):

- Identifying information and presence in treatment
Psychiatric Diagnostic Evaluation
Psychological Testing Results and Report
Substance Use Disorder Assessment
Toxicology Results
Attendance in Treatment
Results of Diagnostic Studies
Lab Results
Treatment Plan
Therapy Notes
Medication Management Notes
Diagnosis
Medications Prescribed
Treatment Summary and Recommendations
Insurance Benefits/Financial Information
Billing Statement of Services Rendered
Correspondence to include: Letters from MBC Phone messages Staff messages Email messages

OTHER: _____

Purpose for releasing/obtaining this information (please check all that apply): Case Management Treatment Planning
Service Coordination Continuity of Treatment Consultation Attorney/Legal/Court Matters Disability Determination

OTHER: _____

The undersigned understands that:

- 1. MBC is not conditioning treatment, enrollment, or eligibility for services on whether I agree to sign this authorization, except in limited certain circumstances.
2. I understand that my records are currently protected under the Federal Privacy regulations within the Health Insurance Portability and Accountability Act (HIPPA), 45 CFR, Parts 160, and 164. The information disclosed pursuant to this authorization may no longer be protected by Federal Health Privacy Rule and may be subjected to re-disclosure without my knowledge or consent or authorization.
3. I have the right to revoke this authorization orally or in writing at any time by contacting the Compliance Officer at 302.674.2380 or 156 S. State Street, Dover, DE 19901. I further understand that any revocation will be effective only to the extent that MBC has not already taken action in reliance on this authorization.
4. This information has been disclosed to the Requestor (MBC) from confidential records protected by State and Federal Statute. State regulations limit the Requestor's right to make further disclosure of this information without prior written consent of the person to whom it pertains.

I understand that my records may be protected under the Federal and State regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, Department of Health and Social Services, Policy Memorandum 5 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that this release automatically expires 30 days AFTER termination of service unless otherwise specified below. In addition, I release the above named organization / individual from all legal liabilities that may arise from this release.

This consent is given freely this _____, 20____ (year) and will expire on _____ (not to exceed one year)

Authorizing Signature: _____ Date: _____

Relationship to Client: _____

Witness: _____ Date: _____