Colony Care
BEHAVIORAL HEALTH

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

I, _____, authorize and request Colony Care Behavioral Health:
(Name of Patient. Print Clearly)

To RELEASE and/or RECEIVE the following verbal or written information:

[ ] Assessment Summary
[ ] Psychological evaluation
[ ] Information relating to ongoing treatment
[ ] Treatment Plan
[ ] Progress towards treatment goals
[ ] Other_____(specify)

To/From:

Name:_____

Street:_____

City:_____ State:_____

Zipcode:_____

Phone #:_____

Fax #:_____

Colony Care Provider:

Name:_____

Street:_____

City:_____ State:_____

Zipcode:_____

Phone #:_____

Fax #:_____

For the purpose of:
[ ] Evaluation
[ ] Treatment Planning
[ ] Other _____

THE TREATMENT DATES COVERED BY THIS AUTHORIZATION ARE FROM _____ TO _____
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to my therapist. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Colony Care Privacy Officer, Dr. Mark Geer.

I understand that the information, which I am authorizing to be released, may be drug/alcohol related information and is protected by Federal Regulation 42 CFR Part II. Such information may not be released without my written consent unless release is specifically provided for in the Federal Regulations.

Date	Patient Signature	Date of Birth
Date	Legal Guardian's Signature (if applicable)	Relationship to Patient