Boone County Health Center
PO Box 151
Albion, NE 68620

Authorization for Bi-Lateral Information Release

Patient Name: _____ DOB: _____
Address _____ Phone Number: _____
City, State Zip _____ MRN: _____

I hereby authorize <u>Boone County Health Center-Behavioral Health Services</u> to release and obtain information with:
Name of Person/Agency: _____
Address: _____
Phone: _____ Fax: _____

Purpose of Disclosure (check all that apply):

□Family Involvement/support
□Coordination of Care
□Disability
□Case Management
□Assessment/Evaluation
□Referral/Additional Resource involvement

Information to be disclosed/obtained (check all that apply):

□Attendance/Compliance Information
□Family History and Social Information
□Progress/Recommendations
□Treatment Summary
□Assessment/Evaluation
□Goals/Treatment Plan
□ Diagnosis/Medication Management
□Other_____

I understand and acknowledge that:

- Information regarding my behavioral health records are being released and I am signing voluntarily.
- My refusal to sign this authorization will not affect my ability to obtain treatment at BCHC.
- Although applicable law may prohibit re-disclosure of these records, it is possible the person/facility that receives the records may re-disclose the information therefore BCHC and its employees have no responsibility or liability as a result of any re-disclosure and such information would no longer be protected by the Privacy Rule.
- IF not previously revoked this authorization/release will expire after **one** year of signature. I understand that I may revoke this authorization at any time by giving written notice. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
- I am entitled to a copy of this completed authorization form.

Notice regarding Drug/Alcohol Abuse related information: This information has been disclosed to you from records protected by Federal confidentiality Rule (42 CFR Part 2). The federal rules prohibit you 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 the 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____
Patient's Signature Date

_____ _____
Witness' Signature Date

If Patient is under 19 years of age the Parent/Legal Guardian must sign.

_____ _____
Parent/Legal Guardian's Signature Date

_____
Relationship to Patient