HAWSE HEALTH

REQUEST TO OBTAIN CONFIDIENTIAL BEHAVIORAL HEALTH INFORMATION

Please Note: Because of the complexity of the laws/regulations governing the release of Behavioral Health Information in may take up to 30 days to determine what records are legally eligible for release.

_____ _____
Last Name, First Name, MI Date of Birth

_____ _____
Address Last 4 numbers of SSN

_____
Home Phone Number Work Phone Number

AUTHORIZATION

I HEREBY AUTHORIZE:
Name/Organization: E. A. Hawse Health Center/Behavioral Health
Address: P.O. Box 97 Baker, WV 26801
Phone Number: 304-897-5915 Fax Number: 304-897-5917

TO RELEASE BEHAVORAL HEALTH INFORMATION TO:
Name/Organization: _____
Address: _____
Phone Number: _____ Fax Number: _____

DATES OF SERVICE: **FROM**_____ **TO**_____

[ ]Medication List [ ]Office Notes [ ]Laboratory Results [ ]Mammogram
[ ]Well Child Visit [ ]Pap Result [ ]X-Ray/Imaging Results [ ]Immunization Records
[ ]Full Medical Records [ ]Behavioral Health Notes

Purpose of Request: [ ]Continued Care [ ]Legal [ ]Insurance [ ]Changing Providers [ ]Other_____

I understand the release of the following information requires special authorization. In addition, there are specific WV, HIPPA, and Federal laws that govern the release of Behavioral Health Records. Per HIPPA Privacy Rule 45 CFR 164.501, Psychotherapy Notes are protected from release, whereas, they are the personal notes of the therapist. In addition, WV Code16-29-1 indicates that "In the case of a patient receiving treatment for psychiatric or psychological problems, a summary of the record shall be made available to the patient…"

Please initial if you wish this information to be requested or released:

____HIV Results or information conveying HIV results
____Behavioral Health/Psychotherapy notes and related medication records
____Records related to treatment of substance/alcohol abuse

Attestations:

____I understand that this consent is voluntary and that I may revoke in writing, signed and dated for E.A. Hawse Health Center. This request will expire in 365 days from the date of signature.
____I may refuse to sign this authorization. If I refuse, the medical records will not be accepted or released.
____Releases or requests meet the requirements of HIPAA
____This release/request has been [ ] accepted [ ] rejected by the patient's representative of record

_____ _____ _____
Patients Signature Guardian Signature Date

Released by: _____ **Date:** _____