HAWSE HEALTH CENTER

Authorization to Release/Obtain Information

I_____, whose date of birth is _____, Authorize:

E.A. Hawse Health Center, Inc., Behavioral Health Department, Address: P O Box 97, Baker, WV 26801

Attention_____

to disclose and/or obtain from:

_____

the following information:

(Client/Patient should initial each item to be disclosed)

Initial	Information to be disclosed	Initial	Information to be disclosed
	Assessment		Educational Information/Behavior Reports
	Diagnosis		IEP Information
	Clinical Evaluation		School Attendance Information
	Mental Health Assessment		School Report Cards/Academic Records
	Psychosocial Evaluation		School SAT Notes/Information
	Psychological Evaluation		Discharge/Transfer Summary
	Psychiatric Evaluation		Continuing Care Plan
	Treatment Plan or Summary		Progress in Treatment
	Current Treatment Update		Progress/Encounter Notes
	Medical Records		Demographic Information
	Medication Management Information		Substance Treatment Records
	Nursing/Medical Information		Verbal Exchange of Information
	Presence/Participation in Treatment		*Psychotherapy Notes
	Other:		Other:

The purpose of this disclosure is to improve
□assessment, □coordination of treatment services, □treatment/service planning, and □continuity of care (mark all that apply).

Revocation- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **E.A. Hawse Health Center –Behavioral Health Services at PO Box 97, Baker, WV 26801**. 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.

Expiration- Unless sooner revoked, this authorization expires on the following date:_____

Conditions- I further understand that E.A Hawse Health Center 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 deem 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.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date