Columbia Community Mental Health (CCMH) Authorization to Use/Disclose Protected Health Information – Mental Health

This authorization is not required to be signed to receive health care services, unless the sole purpose of the health care services is for the release of medical information.

CCMH will disclose only the information that you have authorized and only to those entities that you have authorized unless compelled by law

I, ____________________________ ______________________ ____________________ ____/____/______
(Client) Last Name First Name Middle Name Date of Birth

Authorize CCMH to release the following information.

◯ **Rideshare,** for the purpose of reimbursement**, release only** attendance information

For the purpose of, ____

To, ____

Address ________________________________ City ___________ State _____ Zip ________ Phone ______________

Description of information to be used/disclosed (be specific):

________ All records including: Assessment, Treatment Plan, Progress and Psychotherapy Notes and Labs

◯ Assessments ◯ Service Plan ◯ Progress Notes ◯ Psychotherapy Notes ◯ Labs

________ Other (describe): ____

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place an "X" in the applicable space next to the type of information.

________ Drug/Alcohol diagnosis, treatment or referral information ________ Genetic Testing
________ Mental Health ________ HIV/AIDS
________ Intellectual/Developmental Disabilities

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of information relating to drug/alcohol diagnosis, treatment or referral, genetic testing, mental health, HIV/AIDS and developmental disabilities.

You may revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

I have read this authorization and understand it. Unless revoked, this authorization will continue for 1 year from the signature date; or (time/event) ____.
Treatment after the authorization has expired, and subsequent billing and health care operations related to that treatment will require a new valid authorization. A copy of this authorization is valid as an original. I have a right to a copy of this authorization.

X ____
Signature of Individual or Personal Representative

X ____
Description of Personal Representative's Authority

Date____

REVOCATION:

Date:______________________________

Reason: ______________________________

____