CHARLOTTE
CBHC
Behavioral Health Care

Authorization to Obtain/Disclose Protected Health Information
Release of Information (ROI)

Patient Name: _____ SC ID: _____

DOB: _____ Effective Date: _____

General

This release not only covers the provision and receipt of all records maintained by Charlotte Behavioral Health Care, Inc. (CBHC), but also authorizes any member of the staff, employee of, or entity contracting with CBHC to discuss the case, treatment and records with the person authorized to receive information either in private conversations, depositions, or court testimony. Substance Use Disorder (SUD) records are protected under the Federal regulations governing Confidentiality and SUD Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any information disclosed is taken from the records of which the confidentiality is protected by State (394.459, 397.053, 381.609), (455 and 90) and/or Federal Law (42 CFR, Part 2) (45 CFR 160-164). 42 CFR, Part 2 prohibits CBHC from making any further disclosure without specific written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a SUD (HIPAA, 42 CRF Part 2, and 45 CFR parts 160 & 164) and cannot be disclosed without my written consent unless otherwise provided.

Release To/Release From

☐ Organization/Provider ☐ Individual Type: ☐ Release To ☐ Obtain From

Organization/Individual Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of Disclosure

☐ Process insurance/third party claims (Substance Use Remittance Only)
☐ Care Coordination: to permit continuity of care, keep EAP/Referral Source Informed
☐ HIE (Health Information Exchange)
☐ Other (please specify: i.e., legal reasons, to maintain family involvement in treatment, etc.):
_____

Expiration

If nothing is marked, one (1) year from date signed.

☐ One time disclosure ☐ 6 months ☐ End of Agency Treatment

Start Date: _____ End Date: _____

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Information to be Used or Disclosed

ROI Type: ☐ General ☐ Mental Health ☐ Substance Use Disorder

☐ Attendance Records ☐ Case Management Assessment Adult/Child ☐ Crisis Stabilization Unit
☐ Comprehensive Assessment SUD/MH Adult/Child ☐ Discharge Summary(ies) ☐ Group Notes
☐ Lab Reports, Diagnostic Test, etc. ☐ Progress Notes ☐ Residential and/or Detoxification Services
☐ Psychiatric Evaluation & Medication Management Services ☐ SUD records with no restrictions
☐ SUD records with limitations (only records indicated on this release) ☐ UDS and Lab Results
☐ Other (specify below)

Records Start Date: _____ Records End Date: _____

Restrictions (please specify below)

Terms

- Under state and federal confidentiality provisions only the information specified can be released.
- CBHC cannot ensure the recipient will maintain the confidentiality of the Mental Health and/or Substance Use Disorder (SUD) information authorized and released. If the person or organization obtaining this information is not a health care provider, health plan, or covered under the federal privacy regulations, the information may no longer be protected by federal privacy laws including 42 C.F.R. Part 2 and it could be re-disclosed.
- This authorization will be honored unless revoked in writing. Revocation may be made at any time except to the extent action has already been taken.
- Persons or organizations may not re-disclose substance use treatment information.
- This authorization will expire in one (1) year from the date of signature, unless otherwise specified in the expiration section above.
- This authorization is voluntary. I have been given the chance to ask questions and receive answers pertaining to this document.
- A list of entities to which my information has been released can be provided by CBHC.

By checking these boxes, I agree that I have read, understand and agree to these terms.
☐ Notice to Patient: Signing this form is voluntary and I understand I am under no obligation and my refusal will not affect my ability to obtain treatment.

☐ Access to my Record: I understand I can request a copy of my record. The request will be reviewed and approved by my provider. I understand I can review my records with my provider by making an appointment. The request can take 30 days to complete and charges may apply.

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Other

Copy given to Patient ☐ Yes ☐ Declined a copy Staff: _____

ID verified by: ☐ Driver's License ☐ Other Picture ID ☐ Known to Agency

Additional Information

Please note – The records released may contain alcohol and drug use information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Substance Use

☐ I authorize the release of information relating to referral and/or treatment for alcohol and substance use.

☐ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and substance use.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

☐ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

_____ _____

Signature of Patient Date

_____ _____

Signature of Representative/Legal Guardian Date

_____ _____

Signature of Staff/Witness Date