BOYS TOWN

Behavioral Health Clinic

Authorization to Release/Request Confidential Information

Client Name: _____ Date of Birth: _____

I request protected health information (PHI) for the above named client from Behavioral Health to be:

☐ Released and/or ☐ Requested

Send Information to/from:

Name: _____

Agency (if applicable): _____

Address: _____

Phone: _____ Fax: _____

email address is only required if this is the means of disclosure

Email address: _____

This information is requested for the purpose of:

☐ Further Medical Care ☐ Insurance Eligibility/Benefits ☐ Legal Action/Proceedings

☐ Personal/Request of Service Recipient ☐ Treatment Coordination/Progress

☐ Other (Please Specify) _____

☐ *Substance Use _____

*(Chemical Use Program Only) *Signature of minor (minors must sign for release of substance abuse records)

NOTICE TO RECIPIENTS: You are prohibited from disclosing the information to any other party and are required to destroy the information after the stated need has been fulfilled. This information has been disclosed to you from records, which may be protected by Federal Confidentiality Rules (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 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Information to be released: ☐ MDT/IEP ☐ Psychological Evaluation/Testing ☐ Treatment Summaries

☐ Other _____

Release Format: ☐ Paper ☐ Electronic

Release Method: (check all that apply): ☐ Email ☐ Mail ☐ Fax ☐ Pick up ☐ Verbal ☐ Other: _____

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing to Boys Town Records, at the address listed below. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless revoked, this authorization will expire in one (1) year from the date signed or on the following date/event whichever occurs sooner. Date _____ or Event _____
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information has the potential for re-disclosure, and may not be protected by federal confidentiality rules.
- Requests for copies of records may be subject to fees in accordance with applicable law.
- If I request release by unencrypted email or another unsecure method, I have been warned of and accept the security risks to the information associated with the unsecure transmission, and Boys Town is not responsible for breach notification or liable for disclosures that occur in transit.

Print Client Name (If a minor, person authorized to sign for Client)	Signature of Client (if a minor, person authorized to sign for Client)	Relationship to Client	Date

Boys Town Records: 1655 Palm Beach Lakes Boulevard, Suite 102
West Palm Beach, FL 33401

Phone Number: 561-612-6056
Fax Number: 561-612-6098