



PROTECTED HEALTH INFORMATION RELEASE ACCESS REQUEST FORM

I hereby authorize Northwest Neurobehavioral Health, LLC to DISCLOSE and/or RECEIVE (check one or both) records for:

| | |
|----------------------------|--------------|
| Patient/Client name: _____ | DOB: _____ |
| From/To: _____ | Phone: _____ |
| Address: _____ | Fax: _____ |

The following information: [Check all that apply]

- Initial Evaluation/CDA
- Medication list/progress notes
- Presence/Participation in Treatment
- Treatment Plan (s)
- Evaluation (please list type of evaluation) _____
- Discharge Summary
- Clinical Studies including: Laboratory, EKGs, CT Scan or MRI Results
- Medical History & Physical
- Other (please specify) _____

Conditions- I understand that Northwest Neurobehavioral Health, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have consequences including, but not limited to impacting the outcome of coordinated care.

Please Note- Medical records may contain sensitive information including, but not limited to: Alcohol, Drugs, Mental Health, HIV/AIDS, and Sexually Transmitted Diseases.

Purpose- The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Northwest Neurobehavioral Health, LLC at 2463 East Gala St Suite 100, Meridian, Idaho 83642 . I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.

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.

Expiration- Unless sooner revoked, this authorization expires on the following date: _____, or as otherwise indicated: _____.

Signature of Patient/Client (If 14+ Years of Age) _____ Date _____

Signature of Parent, Guardian or Personal Representative _____ Date _____

(If you are signing as a personal representative of an individual, please describe your authority to act for this individual, for example; power of attorney, healthcare surrogate, etc.)

www.nnhidaho.com 2463 East Gala St Suite 100, Meridian, Idaho 83642 Phone: (208) 955-7333 Fax: (208) 955-7330

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law 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 individual. Authorization for Release PHI – HMO 1026041.doc