North Spring
Behavioral Healthcare
Children are the center of everything we do.

AUTHORIZATION FOR THE USE OF DISCLOSURE
OF PROTECTED HEALTH INFORMATION

_____ _____
(Resident Name) (Date of Birth)

I hereby freely and voluntarily authorize North Spring Behavioral Healthcare, Inc. to:
_____ Release/disclose records of my health information to:
_____ Obtain records of my health information from:

( )
(Individual, Facility, Organization) (Telephone Number)

( )
(Address) (Fax Number)

(City, State, Zip)

The purpose for this disclosure is:
__ To assist in funding
__ To assist in treatment planning
__ To keep the above informed of resident's progress
__ Other (specify)_____
__ To assist in education placement
__ To coordinate discharge planning/placement

The information to be released/obtained included:

	Discharge Summary		Treatment Plans		Psychiatric Evaluation		Verbal exchange of info
	Lab, X-rays, EEG, EKG		History and Physical		Immunization Record		Substance Abuse Treatment
	Polygraph Summary		Risk Assessment/ABEL		Psychological Testing		Juvenile Records
	Education Evaluation		Social History		IEP/504 Plan		Transcript/Report Cards
	Serious Incident Reports		Face Sheet/Demographics		Physician Notes		Daily Progress Notes
	Custody Documentation		IACCT Components		Emergen Services Screen		Other_____

* Psychological, risk assessment, ABEL and polygraph reports are intended for trained professionals, preferably a psychologist or psychiatrist with expertise in the appropriate area. Raw data is not released unless required by law.

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not rediscover them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law. This consent expires on (date):_____

_____ _____
Resident Signature *(Signature required if alcohol or drug treatment is involved)* Date

_____ _____
Parent/Guardian/If Authorized Representative (Describe:_____) Date

_____ _____
Witness Signature Date

*Drug/Alcohol records are protected by Federal confidentiality rules (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigation or prosecute any alcohol or drug abuse resident.