Behavioral Health Choices

Authorization To Release Form For Insurance Purposes

Patient Name:_____Patient's Date of Birth:_____
Patient Address:_____

Information is being released to: (Your Insurance Company):_____
_____

Specific information is to be released: Copies of psychiatric intake evaluation, summary of treatment progress.

Purpose for releasing information: Establishes reasons for providing insurance coverage of mental health services and for additional authorization of services

I understand that my records are protected under a section 5100.34 of the Pennsylvania Mental Health Procedures Act and the Pennsylvania Drug and Alcohol Abuse Control Act, and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in state of federal regulations. I also understand that I may revoke this consent at any time except for the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(specification of dates, event, or condition upon which this consent expires)

I, _____ hereby authorize Behavioral Health Choice to release the information stated above.

Patient: _____ Date:_____

Person Authorized in lieu of patient:_____Date:_____
Relationship of Patient: _____
Witness:_____Date:_____

Prohibition On Redisclosure: Alcohol and Drug Abuse information has been disclosed to you from records who's confidentiality is protected be Federal Law, Federal regulations (42 CFR, Part 2) prohibits you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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.