You may contact our office at 1-855-422-1618

Integrated Behavioral Health

Authorization to Use and Disclose Protected Health Information

Patient Name:	Date of Birth
Address	Phone Number

I hereby authorize **INTEGRATED BEHAVIORAL HEALTH** to

☐ **RELEASE TO**: AND/OR ☐ **OBTAIN FROM**:

Name/title of person or company	Phone Number:	Fax Number
Address		

Please select Information to be Released

□ Appointments □ Insurance Information □ Billing Information □ Financial Information
□ Lab Results □ Diagnosis □ EKG □ Hospital Discharge Summary
□ Consult Note □ Medication List □ Drug Screen Results □ Last 2 office notes
□ Other: _____

Purpose of Use or Disclosure

□ My Personal Use □ Continuity of Care □ Sharing with Other Healthcare Providers
□ Other (please describe): _____

I authorize records to be □ faxed electronically □ fax via fax machine □ mailed

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Including all necessary information containing the diagnosis and records of any treatments and examinations rendered to me during the specified period of time, unless otherwise stated, for the purposes of: continuity of care, improving assessment and treatment planning, sharing information relevant to treatment, and/or coordinating treatment services. I understand this may contain records that could include diagnosis for Mental Disorders and/or Alcohol and Drug treatment issues. Further disclosure of this information is prohibited unless expressly permitted by the written consent of the person to whom it pertains or that person's parent or guardian, as per federal regulations. 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. I understand that this authorization, except for action already taken, may be voided by me at any time**. If this authorization is not voided, it will expire one (1) year from the date signed.**

Initial: _____

_____ _____ _____
Signature of Patient/Representative Date Relationship to Patient

_____ _____
Witness Signature Date

IBH Madison 600 Sun Temple Dr. Madison AL 35758 Fax: 256-325-2728
IBH Decatur 1615 Kathy LN SW, STE 102 Decatur AL 35603 Fax 256-686-4443
IBH Muscle Shoals 1600 Beverly Dr. Muscle Shoals, AL 35661 Fax: 256-320-7476
IBH Cullman 1910 Cherokee Ave SW STE A, Cullman, AL 35055 Fax 256-775-8830
IBH Birmingham 4984 Overton Rd, Birmingham, AL 35210 Fax 205-637-6771

Revised 11/2019