



CBT

CENTER FOR BRIEF THERAPY, PC
&
THE FREEMAN INSTITUTE FOR COGNITIVE THERAPY

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Authorization for Release of Protected Behavioral Health Records

This authorization for release of personal health information is required under the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA Privacy Rule protects the privacy of personal health information contained in your medical records (defined as "protected health information"). This authorization form is necessary to obtain your personal health information for purposes of continuity of care.

I, _____
Name of Patient

Street Address

City State Zip

Date of Birth

Dates of Treatment

authorize the agency professional below
to release TO FROM (Circle one or both)
The Center for Brief Therapy, P.C.

Agency/Professional's Name

Address

City State Zip

Phone Number Fax Number

The following portions of my Medical Record:

- ___ Clinical Assessment ___ Discharge Summary ___ Laboratory Reports ___ Group Therapy Notes
- ___ Psychiatric Eval/Tests ___ Medication Records ___ Progress Notes ___ Psychosocial Assessment
- ___ Treatment Plan ___ History and Physical ___ Diagnostic Reports ___ Alcohol/Drug Assessment
- ___ Physician Orders ___ Psychotherapy Notes ___ Psychological Testing ___ Alcohol/Drug Treatment Records
- ___ Psychosocial Orders ___ Other (please specify): _____

Authorization (Circle YES or NO) I authorize a waiver of 180-day Expiration Period. I have been informed that the State of Indiana, I.C. 16-39-2-5(d), restricts consent to release mental health services information to a 180 day period following the date of my signature. However, the specific purpose of this release extends beyond the 180-day period following my signature. Therefore, I expressly waive my right to the 180-day limitation and authorize this consent to continue until the purpose of the release is fulfilled or until _____(date) whichever comes first. In all cases, the release expires upon formal termination of the clinical record following the conclusion of treatment, and in no case later than one (1) year from execution.

AGREEMENT: I hold harmless the Center for Brief Therapy, P.C. in regard to use of information authorized for release or exchange. I understand this form is not required as a condition for treatment and that it may be revoked in writing at any time, except in the event I have signed a waiver extending the consent beyond the 180-day period. I have read and understand the above and acknowledge that it was properly completed prior to my signature. A photocopy of this authorization is authentic as the original signed Authorization for Release of Information. An original will be retained in my Medical Record. I understand the parties receiving this information will be advised of its confidentiality. This release can be revoked at any time by submitting a written statement.

SUBSTANCE ABUSE SERVICES ONLY: Notice to parties receiving information: Prohibition on Redislosure
This information has been disclosed to you from records protected by Federal confidentiality rules, 42 CFR Part 2. The Federal rules prohibit you from making 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 and 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.

INDIANA CODE: (Release of Mental Health Records to Patient and Authorized Person I.C.16-39-2-1 – I.C.16-39-2-12) Confidentiality - Disclosure A patient's mental health record is confidential and shall be disclosed only with the consent of the patient unless otherwise provided in the following: 1. This chapter (I.C. 16-39-2-1 – I.C. 16-39-2-12) 2. I.C. 16-39-3 (Release in investigations and legal proceedings) 3. I.C. 16-39-4 (Provisions of mental health information) 4. I.C. 16-39-5 (Use of original health record for legitimate business purposes)

DISCLOSURE TO COURT OR PROBATION: If my participation in treatment is a condition of my release from confinement, the disposition of a criminal proceeding against me, the execution of a sentence imposed upon me, or the suspension of a sentence imposed upon me, I understand that treatment information will be shared with applicable court and/or probation personnel. This consent may not be revoked by me unless (1) there has been a formal and effective termination or revocation of my release from confinement, probation, or parole; (2) there has been substantial change in my status. This may occur in the following circumstances: if arrested, when I am formally charged or unconditionally released from arrest; if formally charged, when charges are dismissed with prejudice, or trial has commenced; if brought to trial, which had commenced at the time of this release, when acquitted or sentenced; or if sentenced, when the sentence has been fully executed. It is my responsibility to inform my primary therapist of any such substantial change in status.

For substance abuse information, client must sign, including minors.

Signed: Client

Witness:

Date

Date:

Signed: _____
Legal guardian or parent of minor

MR#: _____