Biltmore Health Services

AUTHORIZATION FOR DISCLOSURE AND THE RECIPROCAL EXCHANGE OF INFORMATION

CLIENT NAME: _____ MR#: _____

MEDICAID ID#: _____ DOB: _____

I hereby request and authorize **Biltmore Health Services.** or contracted agent to release and exchange information to:

(Name of agency/person/facility or program authorized to use or disclose information)

Person/Agency	Address	Phone No.	Fax No.
_____	_____	_____	_____

(The following information will be released or exchanged (mark all that apply)

☐ Psychological Evaluation	☐ Medication History
☐ Psychiatric Evaluation	☐ Admissions Assessment
☐ Progress Note	☐ Insurance Information
☐ Discharge Summary	☐ HIV/AIDS information
☐ Treatment Plan and Diagnosis	☐ Other (specify):
☐ Alcohol/Drug treatment	☐ Other (specify):

Time Frame of Information to be Released _____ to 90 days post D/C.

The purpose of this disclosure is for _____

Once information is disclosed pursuant to this signed authorization, I understand that the federal privacy law (45 C.F.R. Part 160 & 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health and developmental disabilities information protected by state law or substance treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by the laws. All information and records that identify a person who has HIV/AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to state law shall be strictly confidential.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on the consent. In any event, if not revoked earlier this authorization expires automatically one year (365 days) from signature date.

I understand that I may refuse to sign this authorization form. I understand that **Biltmore Health Services will** begin and continue client's treatment and services upon receiving my signature on this authorization. I certify that this authorization is made freely, voluntarily, and without coercion. I understand health insurance and information will be disclosed.

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Witness: _____ Date: _____

☐ **I hereby revoke the above authorization to release or exchange confidential information, or alternatively, see attached statement requesting revocation signed and dated by the above name person or guardian.**

Client: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Staff, if revoked verbally _____ Date: _____