## **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Patient Name:		Date of Birth:	Phone #:
	(please print)		
I authorize:		nberlawn Behavioral Health Sys 4600 Samuell Blyd. Dallas, TX 75228	
To obtain	information from	release information to  ve	rbally provide a status update
	Nan	ne of Person or Entity Relatio	nship
		Address	
Phone #		City Fax	#
My initials below signify the Drug/Alcohol Abuse HIV or AIDs related inform			be released to the above individual/entity.
reatment Dates:			
nformation that may be re ∐List of Medications		_	
History and Physical Ex Discharge Plan/Continu		☐Laboratory Results ☐Discharge Summary	Other (Specify):
URPOSE FOR WHICH I _ Continuing Care _ Legal			ns
for legal purposes, give sp		be completed)	
understand that I may revol evocation must be in writin	ce this authorization g. Without my expr ce for Privacy Practic	at any time, except to the extent that a ress revocation, this consent will autor ces regarding authorized disclosures.	ve is accurate to the best of my knowledge. action has already been taken to comply with it, matically expire upon satisfaction of the need for A legible copy of the Authorization or my
ederal regulation (42 CFR, Pa emitted by the written consent	rt 2) prohibits you fron of the person to whom is not sufficient for this	it pertains, or as otherwise permitted by s purpose. The Federal Rules restrict any u	ny be protected by Federal Law:  ormation unless further disclosure is expressly  uch regulations. A general authorization for the release  use of the information to criminally investigate or
mberlawn Behavioral Health S	System will not condition	on treatment, payment, enrollment or eligi	bility for benefits based on the completion of this form.
is consent expires one year f	rom the date below _	unless otherwise specified (ca	nnot exceed one year):
gnature of Patient	Date	Signature of Parent/Guardia	nn, if applicable Date
itness, if applicable	Date		
evocation: I hereby rev	oke the above auti	horization: Signature	Date
MBERLAWN BEHAVIORA	L HEALTH SYSTEM		
UTHORIZATION TO ROTECTED HEALTI	RELEASE	ON	Patient Identification
141 2/17			
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