Unity Behavioral Health

Authorization for Release of Information

Client Name:			**Date of Birth:**
I hereby authorize Unity to release and/or exchange my personal health information as described below to:			
Person/Entity Name:			**Phone Number:**
Address:			**Email:**
Type of Information to be Released/Exchanged:			
__ Diagnostic Assessment(s)	__ Treatment Plan(s)	__ Progress Note(s)	__ Dates of Service
__ Behavior Risk Assessment(s)	__ Safety Plan(s)	__ Crisis Assessment(s)	__ Screening Tools
__ Billing/Financial	__ Demographics	__ Transfer Summary	__ Discharge Summary
__ Treatment Progress	__ Other:		
Purpose of Disclosure:			
__ Continuity of care	__ Coordination of Services	__ Client Request	__ Other:
Dates of Service to Release:			
FROM (mm/dd/yyyy):		**TO** (mm/dd/yyyy):	

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time upon written notice to Unity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If not date or event is specified below, this authorization will expire in one year.

Expiration Date or Event (mm/dd/yyyy):

- I understand that I may refuse to sign this authorization and that Unity will not condition treatment, payment, enrollment, or eligibility on whether or not I sign this authorization.
- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164]
- I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10,1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

Signature of Client:	Date:
Signature of Parent/Guardian/Representative:	Date:
Name and Relationship of Parent/Guardian/Representative:	