DOVER BEHAVIORAL HEALTH SYSTEM
725 Horsepond Road
Dover, DE 19901
TELEPHONE: (302) 747-1112 FAX (302) 346-4582

AUTHORIZATION TO OBTAIN AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Medical Record #(completed by hospital): _____

Date of Birth: _____ S.S.#: _____ Contact#: _____

I authorize the use of disclosure of the above named individual's health information as described below:

The following organization is authorized to **OBTAIN and/or DISCLOSE (*CIRCLE ONE OR BOTH)*** the selected information to the person listed below:

Dover Behavioral Health System
725 Horsepond Road
Dover, DE 19901

The type of information to be used or disclosed is limited to the following:
- ☐ Verbal Only
- ☐ Admission & Discharge Dates Only
- ☐ Discharge Summary
- ☐ Psychiatric Assessment
- ☐ Continuing Care/Discharge Instructions
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Psycho educational/Therapy Transcripts
- ☐ Psychological Evaluations
- ☐ Other: _____

I understand that the information in my health record may include information related to sexually transmitted diseases, including HIV/AIDS. It may also contain information about treatment for alcohol and drug abuse.

The information may be obtained from or disclosed to the following individual or organization:

CIRCLE ONE: REFERRAL SOURCE THERAPIST PSYCHIATRIST CCCP PCP
SCHOOL/WELLNESS CENTER PROBATION EMPLOYER FAMILY MEMBER OTHER

_____
(Individual or Organization) (Address)

for the purpose of: _____

This Authorization to Release Protected Health Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), standards for privacy of individually identifiable health information standards, 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereof. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Department of Health Information Services at Dover Behavioral Health. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 120 days.

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 any 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 or 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. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

Patient's Signature: _____ Date:_____

Guardian/Parent Signature:_____ Date:_____

Witness Signature:_____ Date:_____