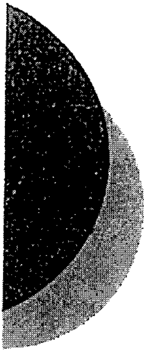

Brain Health Center

3100 Route 138 West
Building 2, Suite 1
Wall Township, NJ 07719

848-404-9111
www.brainhealthcenter.com

Authorization for Use and Disclosure of Protected Information

This authorization form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164; the federal drug and alcohol confidentiality law, 42 C.F.R. part 2; and NJ confidentiality law governing mental health and substance abuse services.

Client Name: ______________________________ Date of Birth: ______________

I, ______________________________ request and authorize Brain Health Center to obtain
(Name of client or client's legally responsible person/personal representative)
from and or disclose to:

____
(Name of Individual or Entity)

____
(Street Address) (Town) (State) (Zip Code)

the following protected information: (*Circle yes or no on the following specific information.*)

* Assessment (yes) (no) * Substance Abuse Evaluation (yes) (no) * Laboratory Results (yes) (no) * Qeeg Summary (yes) (no)

* Treatment Plan (yes) (no) * Progress Notes (yes) (no) * Attendance (yes) (no) * Discharge Summary (yes) (no)

* Medication Information (yes) (no) * Psychiatric Evaluation (yes) (no) * Academic History & Current Performance (yes) (no)

* Compliance (yes) (no) * Other/*Specify:* ______________________________

Purpose: ______________________________

This information may be given ______________________________
(Indicate frequency)

Since I have signed authorization to release this information, I understand that the federal privacy law (45 C.F.R. Part 164) may not apply to who receives this information and, therefore, the information could be given to others. However, other laws may prohibit this. When we disclose mental health information protected by state law (NJ Administrative Code-Title 10) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we inform those we are sending this information to that releasing it again is prohibited except in the circumstances that the law allows. Our Notice of Privacy Practices describes those circumstances for disclosing information.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy). In any event, if not revoked earlier, this authorization expires automatically one year from date signed.

Instructions for Revocation of an Authorization: Please put in writing request for revocation, specify what information you do not want disclosed and forward the request to your treating provider.

Client Name (please print)	Client Signature	Date
Name or Parent of Legal Guardian (please print)	Parent or Legal Guardian Signature	Date
Name of Staff (please print) witness	Staff Signature	Date