Patient's Full Name: ______________________ Date of Birth: ____________

Address: ______________________ Phone Number: ____________

I hereby authorize:
- ❑ Parkview Regional Medical Center
- ❑ Parkview Hospital Randallia
- ❑ Park Center
- ❑ Parkview DeKalb Hospital
- ❑ Parkview Huntington Hospital
- ❑ Parkview LaGrange Hospital
- ❑ Parkview Noble Hospital
- ❑ Parkview Ortho Hospital
- ❑ Parkview Wabash Hospital
- ❑ Parkview Whitley Hospital
- ❑ Parkview Behavioral Health
- ❑ Parkview Physicians Group (practice type): ______________________
- ❑ Other: ______________________

(individually or collectively, "Parkview") to release my mental health and substance use disorder treatment records information to the following individuals and/or entities, for the following purposes:

Name: ______________________

Address: ______________________

The purpose for which the information is being requested: ______________________

Mental Health/Substance Use Disorder Treatment Records to be released under this Authorization:

Date(s) of Service(s): ______________________

- ❑ History and Physical
- ❑ Progress Notes
- ❑ Physician Orders
- ❑ Psychosocial Assessment
- ❑ Medications
- ❑ Psychiatric Eval/Tests
- ❑ Discharge Summary
- ❑ Treatment Plan
- ❑ Psychosocial Eval/Tests
- ❑ Psychological Testing Results
- ❑ Substance Use Disorder Assessments
- ❑ Substance Use Disorder Treatment Records
- ❑ Other (please specify): ______________________

To authorize the release of medical/surgical records a separate Authorization For Release of Medical Records must be completed.

Authorization for Disclosure of Mental Health Records under State law: Except where prohibited under Federal law, I authorize the release of all mental health records to an insurer that has issued a policy of accident and sickness insurance covering the services provided to patient.

I understand that I may revoke this authorization at any time by sending written notification to Parkview at Attn: HIM Release of Information 2200 Randallia Drive, Fort Wayne, IN 46805, except to the extent that action has already been taken in reliance upon this authorization. If not previously revoked, this authorization will terminate on the following date, event or condition:______________. If no date, event or condition specified, this authorization will expire after 3 years.

I may request of copy of my own records. If I do, I will agree to pay the facility the costs incurred by Parkview Health in preparing the copy of the requested mental/behavioral health records as allowed by State and Federal guidelines.

I understand that I may be denied services if I refuse to authorize a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to authorize a disclosure for other purposes.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by federal law, except for substance use disorder treatment information.

I understand that I am entitled to a copy of this authorization. If this form is signed electronically, by placing my name below, I consent to the use of electronic records and authorize the uses and disclosures described above.

Printed Name: ______________________

Patient/Parent/Guardian/Legal Representative Signature: ______________________ **Date:**__________ **Time:**__________

Relationship to Patient: ❑ **Self** **If other than self, must specify:** ______________________

FOR FACILITY PERSONNEL ONLY

❑ Patient Identification Verified. Signature: ______________________ Date:__________ Time:__________

Hospital Personnel Receiving Form

NOTE: Important notices about legal requirements for the treatment of mental/behavioral health records, including substance use disorder treatment records, are on the back of this form.

Patient Name: ______________________

Medical Record Number: ______________________

Date of Service: ______________________

All entries must be dated and timed.

AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH RECORDS

White - Chart Yellow - Requestor

HIMROI

NOTICE

If the attached records contain information regarding mental health and/or substance use disorder treatment subject to 42 CFR Part 2, please read and follow the information presented below.

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. The following restrictions and requirements may apply to the use and disclosure of these records.

Confidentiality of Substance Use Disorder Records - Restriction on Disclosure (42 CFR Part 2)

a. Patient information, including but not limited to, the identity, diagnosis, prognosis or treatment of any patient, may not be disclosed except for the following purposes:
   1. When disclosed in accordance with valid prior written consent of the patient.
   2. To medical personnel to the extent necessary to meet a bona fide medical emergency.
   3. To qualified personnel for purpose of scientific research, subject to the requirements at §2.52.
   4. For audits or program evaluation, subject to the requirements at §2.53.
   5. As ordered by an appropriate court order of competent jurisdiction, subject to the requirements at 42 CFR Subpart E.5. To central registries in order to prevent multiple enrollments in substance use disorder care, duplicative prescriptions for substance use disorder treatment, and adverse drug events related to substance use disorder treatment.

b. A minor patient's authorization may be required for disclosure, even to his or her parent, guardian or other legal representative.

c. There are exceptions to the applicability of 42 CFR Part 2, described at §2.12(c), including, in certain circumstances: (i) exchanges of information among the Armed Forces and Veterans' Administration; (ii) reports of suspect child abuse and neglect to State or local authorities; (iii) reports related to the commission of a crime to law enforcement agencies or officials; (iv) communications with a qualified service organization, within a part 2 program, or with an entity having direct administrative control over a part 2 program.

Medical Emergencies (42 CFR Section 2.51):

a. **General Rule** - Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about the patient for the purpose of treating a condition which **poses an immediate threat to the health of any individual and which requires immediate medical intervention.**

b. **Special Rule** - Release to FDA because of health threat from product manufacturing, labeling or sale error.

c. **Procedure** - Immediately document in patient record: 1. The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility; 2. The name of the individual making the disclosure; 3. The date and time of the disclosure; and 4. The nature of the emergency (or error if report was to FDA).

Indiana Code (Release of Mental Health Records to Patient and Authorized Person I.C. 16-39-2-1 —1.C. 16-39-2-12):

Confidentiality - Disclosure: A patient's mental health record is confidential and shall be disclosed only with the consent of the patient unless otherwise provided in the following:
1. This chapter (I.C. 16-39-2-1 — I.C. 16-39-2-12)
2. I.C. 16-39-3 (Release in investigations and legal proceedings)
3. I.C. 16-39-4 (Provisions of mental health information)
4. I.C. 16-39-5 (Use of original health record for legitimate business purposes)

Additionally ALL medical records are protected by the Health Insurance Portability and Accountability Act (P.L. 104-191 (1996) and regulations promulgated there under) and Title 16, Article 39 of the Indiana Code.

AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH RECORD

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