Patient Name (name used during treatment): _____

Date of Birth: _____ Last 4 digits of Social Security Number: _____

Current Address: _____

_____

Current Home Phone: _____ Cell Phone: _____

I hereby authorize **BETTY FORD CENTER** to release and/or exchange written or verbal protected health information with: ***(This section must be complete for release to be valid. Records will be mailed only to the address provided on this release.)***

Name: _____

Address: _____

_____

Telephone Number: _____

Check here _____ for ALL dates of treatment.
Check here _____ for specific dates of treatment as follows: _____

SPECIFY RECORDS TO BE RELEASED *(All selections may not exist for all patients. Requests must be specific. Do not write "all records.")*

_____ Program Attendance Letter
_____ Disability/FMLA Forms
_____ All treatment records for insurance reimbursement
_____ Discharge documents (e.g., discharge summaries, continuing care recommendations)
_____ Preadmission/Admission Documents (e.g., preadmission assessment, consents)
_____ Medical/Nursing Treatment Records (e.g., History and Physical, orders, medication, notes)
_____ Laboratory/Radiology Reports
_____ Outside Consultation Reports (e.g., dental, dermatology, etc.)
_____ Clinical Treatment Records (e.g., psychosocial, treatment plans, notes)
_____ Psychiatric consultation/assessment/notes
_____ Psychological Evaluation/Test Results
_____ All Administrative Documents (e.g., releases, checklists, facesheet)
_____ Outpatient Clinical Diagnostic Evaluation (CDE) Packet
_____ Accounting/Billing records
_____ Other Specific Record: _____

INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE

_____ Continuation of Care _____ Personal Reasons _____ Insurance Reimbursement

_____ Legal Purposes _____ Other (must specify): _____

Scope	This authorization includes release of records generated during treatment of chemical/alcohol dependency. I understand my records may also contain information regarding mental health issues and/or HIV/AIDS status.
Expiration	This release is valid for one year from the date of my signature below or until revoked by me.
Right to Revoke	I understand I have the right to revoke this authorization in writing, at any time, by sending written notification to Betty Ford Center. I further understand that revocation of the authorization does not apply to information that had already been released in reliance on the authorization.
Fees	Betty Ford Center requires prepayment for the requested copies in accordance with the allowable fees set forth in state and federal law.
Conditions	Betty Ford Center will not condition my treatment on whether I give authorization for the requested disclosure.
Form of Disclosure	Betty Ford Center reserves the right to disclose information as permitted by this authorization in any manner we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.
Redisclosure	Federal law prohibits the person or organization to which disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.
Contact Information	Betty Ford Center Health Information Management Department 39000 Bob Hope Drive Rancho Mirage, CA 92270 (760) 773-4110

Betty Ford Center requires an ***original ink signature*** on this release. Photocopied and/or faxed signatures are not accepted. For your protection, Betty Ford Center reserves the right to request a notarized signature when necessary to verify the identity of a patient.

Patient Name: (Please Print) _____

Patient Signature: _____ Date: _____

FACILITY USE ONLY

STAFF MEMBER INITIALS: _____ NUMBER OF PAGES: _____

DATE SENT: _____ MAIL: ____ FEDEX:____ PICKED-UP: ____
OTHER: _____

NOTES: _____

BETTY FORD CENTER

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION