Southwest Behavioral & Health Services

Release of Information and Records Request Form

Please check only **ONE** of the following options:

☐ Check here if you would like to **Release/Send** your records ☐ Check here if you would like to **Request** your records

☐ Check here if you would like to **both Release AND Request** your records

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How would you like to receive your records? Please select: ☐ Mail ☐ Digital format via Mail (50 page minimum required) ☐ Email: _____

Dates of Service (for records to be sent): ☐ past 60 days ☐ past 90 days ☐ past year

☐ Other (list date range): __/__/____ to __/__/____

I, _____ _____ __/__/____

Your Name SSN Date of Birth

_____ _____

Address Phone Number

_____

City, State, Zip

Authorize releases, and/or record requests as selected herein between:

Southwest Behavioral & Health Services _____

Name of Healthcare Organization with Treatment Relationship Phone Number

_____ _____

Address, City, State, Zip Fax Number

AND

_____ _____

Name of Person and Agency (Recipient) Phone Number

_____ _____

Address, City, State, Zip Fax Number

Notice to Recipient: On February 16, 2024, the U.S. Department of Health & Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office for Civil Rights announced a final rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR part 2. The modification allows a single consent for all future uses and disclosures for treatment, payment, and health care operations. It also allows HIPAA covered entities and business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations. However, a separate consent will be required for the use and disclosure of SUD Counseling notes.

What kind information would you like released and/or requested as selected herein? Check all that apply:

☐ Clinical Assessment ☐ Psychiatric Evaluation ☐ Test Results/Labs

☐ Clinical Services Notes ☐ Treatment/Service Plans ☐ AIDS/HIV Information

☐ Discharge Summary ☐ Verbal disclosure of treatment information ☐ School Records

☐ Psychological Assessment ☐ Medications ☐

☐ Other (Please specify i.e. billing records, treatment summary, etc): _____

Purpose for Release/Request: _____

A purpose for the request/disclosure is required for all 3rd party releases only. This section identifies to the authorized party and signer why the records are being requested and/or what the records will be used for. The purpose is not required when members are requesting their own records. **I understand** that at anytime, I may revoke this authorization by writing to SBH in keeping with SBH Policies and Procedures. The revocation will be effective except to the extent that action based on this authorization has already been taken. You are referred to the SBH Notice of Privacy Practices for further information regarding your rights under federal law (HIPAA: 45 CFR 160-164).

Authorization will expire:

☐ 1 Year From this Date ☐ Other: __/__/____ (Enter Date, no greater than 1 year)

_____ _____

Signature of Member/Guardian/Authorized representative Date

_____ _____

Other Required Signature (If Applicable) Witness (if Member is unable to sign)

***If patient is between 12-17 years of age, both his/her signature and the signature of parent/legal guardian may be required.**