Gulf Coast Mental Health Center
1600 Broad Avenue • Gulfport, MS 39501
(228) 863-1132 • Fax: (228) 865-1700

Name: _____ Case #: _____

DOB: _____ SSN: _____

AUTHORITY TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

I, _____ **or**
(Individual Receiving Services)

I, _____ for _____ hereby authorize
(Parent/guardian/or judicially authorized representative)

Gulf Coast Mental Health Center to: ☐ release ☐ obtain ☐ release ***and*** obtain my protected health information/records to/from

_____
(Name of Person & Title or Entity and Address to whom/from whom information will be disclosed/obtained

I specifically authorize/consent to the release or obtaining of health information and/or records pertaining to the following: **Individual receiving services must check (✓) beside each type of health information to be obtained/released:**

- ☐ Admission Summary / Discharge Summary
- ☐ Activity Plan
- ☐ Lab Reports
- ☐ Medication Records
- ☐ Psychiatric Records
- ☐ Contact Summaries
- ☐ Substance Abuse Records
- ☐ Evaluations
- ☐ Other (Describe other information/records to be disclosed/obtained)

_____

- ☐ Identifying Information
- ☐ Case Notes / Progress Notes
- ☐ Medical History & Physical Examinations
- ☐ Diagnosis/Prognosis and/or Recommendations
- ☐ Individual Services Plan / Treatment Plan
- ☐ Alcohol/Drug Usage information
- ☐ HIV / AIDS Information

*I understand that I have the right to refuse to disclose HIV test results. ☐ I DO NOT AUTHORIZE release of HIV test results.

Dates of service for which the information/record is requested or will be released: From: _____ To: _____

I understand that the information I authorize for release may include information that could be considered information about communicable or sexually transmitted diseases.

For the specific purpose of: ☐ Treatment and the coordination of services ☐ Individual's Request ☐ Billing Purposes
☐ Other _____
(describe purpose or nature of the information to be disclosed/obtained)

I understand that I may revoke this consent at any time except to the extent that action has been taken. I further understand that this consent will expire on _____ and cannot be renewed without my consent.
(Specific Date / Event / Condition)

I understand that to revoke this authorization, I must provide a written request and the revocation will not apply to action or information that has already been released/obtained in response to this authorization. Any information obtained as a result of this release is confidential. State and federal laws and regulations prohibit any entity without the specific written consent of the person to whom it pertains or as otherwise permitted by law and regulations. I understand the information I authorize for release may include information related to history/diagnosis and/or treatment of HIV, AIDS, communicable or sexually transmitted disease, and alcohol/drug abuse or dependency.
By signing below, I acknowledge receipt of a copy of the signed authorization.

_____ _____
Individual Receiving Services Date Legal Representative Date

_____
Signature of Witness / Credentials Date

NOTE TO PROGRAM RECEIVING THIS INFORMATION REGARDING RE-DISCLOSURE: This information has been disclosed to you from records, the confidentiality of which is protected by state and/or federal law(s) or regulations. These laws/regulations prohibit you from making further disclosure of this information without the specific written authorization/consent of the person to whom it pertains or of other persons as permitted by law. **A general authorization for the release of medical or other information is not sufficient for this purpose.** (Reference, 42 CFR, Part 2.).

(Facility staff must provide a copy of the signed authorization to the individual receiving services and/or judicially authorized representative.)

WHITE - ORIGINAL YELLOW - CHART PINK - INDIVIDUAL