DATE

Release of Information

I authorize release and/or acquisition of the following information from Renaissance Behavioral Health Center to the following individuals listed at the bottom of this form:

Presence of Information
Progress in Treatment
TreatmentPlans
PsychologicalAssessment
Psychiatric History and Assessment
ResultsofPhysicalExam
MedicalHistory/Current Status
BiopsychosocialAssessment
Laboratory Test Results
EmploymentInformation
LegalStatus
FamilyInformation
Aftercare Recommendations
DischargePlanning
Discharge Summary
Other(specify) Other:

Reason for release of information (Under the Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure):

Continuity of Treatment- Patient History- Case Management Services
EmergencyContacts- General Updates
CourtServices- Legal Purposes- Probation- Disability Claiming- Unemployment Claiming- Employment Continuity
Other(specify) Other:

_____

Renaissance Behavioral Health, LLC

2701 E. Monument Street,
Baltimore, MD 21205

jsmith@renaissance-bh.com
www.Renaissance-bh.com

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

I understand that I may revoke this authorization at any time upon written notice to Renaissance Behavioral Health. I acknowledge that such revocation will not be effective if Renaissance Behavioral Health has already acted in reliance upon this authorization.

This authorization is valid (if not previously revoked) this consent will terminate upon 365 days from the date of signature of this form, or the completion of treatment, or at the time of the final insurance billing, as the case may be, whichever is later.

Prohibition on Re-disclosure:

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.

Print Name_____

Signature _____

Date _____

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