Sunburst Mental Health

Authorization to Use/Disclose Protected Health Information

Patient Information (Print your name or the name of the patient whose information is to be released.)	Name				Birthdate	
	Other Names Used					
	Mailing Address					
	City		State		Zip	
Health Care Provider (Who has the information you want released? Be specific)	Facility Name					
	Address					
	Phone		Fax			
Receiving Party	**Sunburst Mental Health**					
	Address					
	City	Kalispell	State	MT	Zip	59901
	Phone	406-756-8721	Fax	406-257-4054		

Information to be Released (What do you want sent or released? Check the appropriate box or boxes.)	Date Range of Information to be Released (MM/YYYY)	From:	To:
	Check Information to be Released ☐ Entire Record ☐ Emergency Records ☐ Discharge Summary ☐ History and Physical ☐ Pathology Reports ☐ Laboratory Reports ☐ Psychiatric Diagnostic Eval ☐ Psychiatric Medication Eval ☐ Substance Use Disorder Eval ☐ Performance Management ☐ Treatment Plan Summary ☐ Active Medication List ☐ Other (specific to care):		
Release Instructions (How and when do you want the information?)	Date Information is Needed		Please allow **7-10** business days for processing
	Disclosure Method	☐ Pickup ☐ Mail ☐ Digital Copy ☐ Fax	
	Secure Email Address		

By signing this authorization form, I understand that:

- Information about my behavioral health services to include mental health and substance use diagnostics in accordance with all federal and state privacy and security regulations.
- *Psychotherapy notes and substance use disorder treatment notes have additional privacy and security protections.
- Information in my health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), viral hepatitis, and genetic information.
- Information used/disclosed is solely intended for the receiving party and re-disclosure is unauthorized. However, we are unable to assure protection from re-disclosure from the receiving party.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law.
- I have the right to revoke this authorization at any time. Revocation must be in writing and on file. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: ___________________. Failure to specify an expiration date/event/condition, this authorization will expire **one (1) year** from the date it is signed.

Signature		**Date**	
Printed Name			

Signature/ID Verified ☐ Yes ☐ No	MRN#	# Pages Released	
Completed by:		Date	

I hereby revoke (cancel) this Authorization to Use/Disclose Protected Health Information.			
Signature		Date	

***45 CFR 164.501; 45 CFR 164.512; 45 CFR 164.524; 45 CFR 164.526; 45 CFR 160.103; 42 CFR Part 2**