Authorization to Release Client-Specific Information

Policy
It is the policy of Central Florida Behavioral Health Network (CFBHN) to ensure that the network and its Network Service Providers (NSP) comply with all federal and state regulations, including the Health Insurance Portability and Accountability Act (HIPAA), regarding the authorization for uses and disclosures of Protected Health Information (PHI), and 42 CFR Part 2 which protects the confidentiality of records of patients treated or referred for treatment for substance use.

Purpose
The purpose of this policy is to outline guidelines for the use of the CFBHN Authorization to Release Client Information form.

Procedure
1. Privacy rules prohibit healthcare providers and Business Associates from using or disclosing PHI unless they have a valid, written authorization signed by the patient or the patient's personal representative.

2. To be valid authorization, it must contain each of the elements below.
   A. Core Elements
      1) The name of the client who is the subject of the disclosure.
      2) The name or specific identification of the person(s), or class of person(s) or organization authorized to make the disclosure.
      3) The name(s) or other specific identification of the person(s) or class of person, or organization to whom the covered entity may make the requested disclosure.
      4) A description of the PHI to be used or disclosed. This description must specifically identify how much, or the dates, of the information to be released, and what kind of records are permitted for disclosure.
      5) For each requested use or disclosure, the purpose of the disclosure must be provided. If the patient initiates the authorization, a statement that the disclosure is "at the request of the individual" is sufficient.
      6) An expiration date or event that relates to the length of time for which the authorization is in effect. For example, a specific date or statement such as "Until completion of litigation".
      7) The date and signature of the patient or the patient's personal representative. If the Authorization is signed by an individual's personal representative, a description of the representative's authority to act for the individual should also be included.

   B. Required Statements
      1) Special protections related to confidentiality exist for those who have undergone treatment for substance use at a federally-assisted program. As such, the following notice must accompany each disclosure of substance use treatment records, or records that include both substance use and mental health treatment:

Authorization to Release Client-Specific Information (continued)

"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 2.6."

2) For records that include only mental health treatment information, three required statements must accompany the disclosure:
   a) "You or your personal representative have the right to revoke the authorization at any time by submitting a written revocation to the CFBHN Chief Operating Officer (COO0, Chief Clinical Officer (CCO) and/or Privacy Officer. The revocation will be immediately put into effect, except to the extent that CFBHN has taken action on the original authorization."
   b) "CFBHN does not condition your treatment, payment, health plan enrollment or benefits eligibility on the provision of this authorization."
   c) "Information disclosed by this authorization is subject to re-disclosure by the recipient and is no longer protected by HIPAA."

C. Compound authorizations, defined as those that combine an authorization to release information with another legal permission, are not permitted.

D. The authorization must be completed in full.

E. The authorization must be written in plain language. For patients with limited English proficiency, the provider may need to translate the consent for the patient.

F. If the provider is requesting the authorization from the patient, the provider must give the patient or personal representative a signed copy of the authorization. The provider is not required to give a copy if the patient initiated the authorization.

G. The original signed, completed Authorization to Release Client Information must be filed in the client's medical record, or retained by CFBHN.

Authorization to Release Client Information	Date Issued: 11/05/2002
Approval: Linda McKinnon Linda McKinnon, President/Chief Executive Officer	Last Revision: 04/06/2021 Review Date: 02/03/2022

Authorization for Release of Information

Instructions: Please complete the information requested on Pages 1 & 2 of this form.
(Note: if the patient is a minor, this form must be completed by a parent or legal guardian).

1. Records from: Crossroads Behavioral Health Center | Hendry-Glades Behavioral Health Center | Other (Please specify): _____

2. Date Range of Records Requested (circle one): ALL or Date range: _____ (Start Date) to _____ (End Date)

3. Type of Records Requested (circle one): ALL or Please list the type of records that you are requesting:

_____

If there are specific types of records you want EXCLUDED please describe: _____

_____

4. Patient's Name: _____ **Date of Birth**: _____

5. Name of the Individual Making this Request: _____

Address: _____ **Phone Number**: _____

PLEASE NOTE: If the individual requesting the record is not the named patient, indicate the level of authority that you possess to access their health record. A copy of the legal documentation that authorizes your access MUST also be provided to CFBHN along with this Authorization form.

☐ Parent ☐ Power of Attorney ☐ Legal Guardian ☐ Healthcare Surrogate

Other (please describe): _____

6. Individual to Receive the Record (Include their name and the address to which the record should be sent):

_____

_____

7. For what purpose is this record requested?

_____

_____

8. If this authorization is granted for a limited period of time, please indicate its expiration date. (If this Authorization is not time-limited, please write 'none.'): _____

Please complete Page 2 of this form.

Please read the statements that follow, and sign and print your name below

- I hereby request and authorize Central Florida Behavioral Health Network, 719 U.S. Highway, 301 South, Tampa, FL 33619 to release the requested record.
- I understand that:
  - The record I have requested may include mental health and substance abuse treatment information, including test results, assessments, lab reports, and HIV status and that the confidentiality of this patient's health information is protected.
  - Re-disclosure of this record may be prohibited, unless authorized in writing by the patient or their legal representative. Florida Law requires that any person, agency, or entity receiving information shall maintain it as confidential and exempt from the provisions of the public records law.
  - I have the right to rescind my authorization at any time prior to the release of the requested information.
- I attest that I have a legal authority to make this request.

PRINTED NAME of the Individual Authorizing this Request:	
SIGNATURE of the Individual Authorizing this Request:	
DATE and TIME that Authorization was Completed:	

FOR CFBHN USE ONLY:

Date and time that signed Authorization and any required documentation was received from requestor:	
Date and time that CRM was contacted to retrieve record:	
Date and time that record was received from CRM:	
Date and time that requested records were released:	
Traceable method used to send record and ID number:	
Verified date and time that requestor received the record:	
Printed name of CFBHN staff member who verified that this request is complete:	
Signature of CFBHN staff member who verified that request is complete:	