Balance Treatment Center

4505 Las Virgenes Rd., Suite 201, Calabasas, CA 91302
Tel 818-880-0800 Fax 818-880-0808 www.BalanceTreatment.com

AUTHORIZATION FOR RELEASE, RECEIPT, OR EXCHANGE OF MEDICAL AND MENTAL HEALTH INFORMATION

Completing this document authorizes the release, receipt, or exchange of health information about you. Failure to provide all information requested may invalidate this Authorization.

Client Name: _____
Medical Record Number: _____ Client DOB: _____

I hereby authorize:

Balance Treatment Center
4505 Las Virgenes Rd., Suite201,
Calabasas, CA 91302
Tel 818-880-0800
Fax 818-880-0808

☐ to release
☐ to receive and use
☐ to exchange and use health information described below to/from/with:

Name: _____
_____

Relation to Client: _____

Address: _____
_____

Cell Phone: _____
Other Phone: _____
Fax: _____

Type of disclosure:

☐ Verbal Information ☐ Billing Information ☐ Copies of Record ☐ Letter

Please specify the information you authorize to be released, received, or exchanged:

☐ Entire Treatment record of care received at Balance Treatment Center
☐ Only the specific records or types of information identified below:
- ☐ Assessment/Evaluation
- ☐ Diagnosis/Condition
- ☐ Drug Testing/Lab Results
- ☐ Medication History/Current Medications
- ☐ Dates of Treatment/Attendance Confirmation
- ☐ Treatment Plans/Objectives/Progress
- ☐ Discharge Summary and continuing care information

Limitations upon disclosure: _____
_____
_____

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this Authorization will expire 12 months after the date of my signing this form.

NOTICE: Balance Treatment Center and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect it.

YOUR RIGHTS: Signing this Authorization to release health information is voluntary. You may refuse to sign this Authorization. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1 conduct research-related treatment, (2 to obtain information in connection with eligibility or enrollment in a health plan, (3 to determine an entity's obligation to pay a claim, or (4 solely to create health information to provide to a third party (5 when using insurance for coverage of treatment.

This Authorization maybe revoked at any time expect to the extent that action has been taken in reliance on it. If you choose to revoke this Authorization please identify the following:

☐ Time/Date of Revocation: _____
☐ Staff members notified of Revocation/Title: _____

This signed revocation of the Authorization will be delivered in person, mailed or faxed to:
Balance Treatment Center, Attention: Privacy Officer
4505 Las Virgenes Rd., Suite 201 Calabasas, CA 91302
Fax 818-880-0808

The revocation will take effect when Balance Treatment Center receives it, except to the extent that Balance Treatment Center has already relied on the Authorization.

You may inspect or obtain a copy of the health information that you are asking to or being asked to allow to be released, received and or exchanged. You are entitled to receive a copy of this Authorization. If you sign it, you have a right to a copy of the document that you sign.

I understand that my health care records and any alcohol and/or drug treatment records are protected under California law and Health Insurance Portability and Accountability Act of 1996 ("HIPAA", 45 C.F.R. Sections 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in law or regulation. I also understand that California has specific protections for drug and alcohol treatment and mental health treatment records.

I understand that information disclosed as a result of the Authorization could be re-disclosed by the recipient. In some cases, such as re-disclosure would not be permitted by California law and then would not be protected under federal HIPAA law. However, California law prohibits the person receiving my health care information from making further disclosure of it uncles another authorization for such disclosure is obtained by me or such disclosure is specifically required or permitted by law. If the disclosure consists of treatment information about a client who is in a federally assisted drug or alcohol abuse program, the Recipient may not disclose such information unless permitted by the client or permitted under federal law.

Client Name Printed: _____ Time: _____

Client Signature _____ Date: _____

Signature by client/guardian/conservator or legal representative:

When a client is not competent to give consent, the form is to be signed by a health care agent, or other legally approved representative.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use and disclosure of my medical information.

Client Representative Full Name: _____

Client Representative Relation to client: _____

Client Representative Signature: _____ Date: _____

Staff Name and Title Completing this Form: _____

Staff Signature: _____ Date: _____

☐ The client was offered and given a copy of this signed Authorization.
☐ The client was offered and declined a copy of this signed Authorization.
