Authorization for Release of Protected Health Information

Client Name					Social Security Number	
Street Address					Date of Birth	
City		State	Zip Code		Phone Number	
I authorize	Name of Provider Agency					
	Street Address	City		State	Zip Code	

to disclose my Protected Health Information, including Mental Health, Drugs and Alcohol and HIV/AIDs specific information, to:

☒Broward Behavioral Health Coalition's (BBHC) ☒ Carisk Partners

☒All BBHC-affiliated providers and State Mental Health Treatment Facilities ☐ OCP2 Evaluators

☐Broward County Homeless Initiative Partnership/Homeless Management Information System (HMIS)/Service Point.

for the purposes of:

☒ Listing me on a secure, centralized, network-wide waitlist ☐ OCP2 Referral

☒ Decreasing the length of time I have to wait for services I need ☐ LIT Referral

☒ Improving coordination of my care among network providers

☐ Homeless history verification and housing prioritization, coordination and placement and

☐ Other:____

I specifically authorize release of the following protected health information, including my Mental Health, Drugs and Alcohol and, if applicable, HIV/AIDs information:

☒ All of the following behavioral health records as needed to add me to the BBHC waitlist and to secure my placement with another provider(s) offering services I need:

☒ Mental health history, diagnosis and treatment information, including psychiatric and psychosocial evaluations and excluding psychotherapy notes.

☒ Substance (drug and alcohol) abuse history, diagnosis and treatment information.

☒ HIV/AIDS and other communicable disease test results and diagnosis and treatment information.

☒ Legal records and court documents affecting other providers' willingness to accept me for services.

☒ Protected health information detailing my medical conditions, diagnoses and treatment that affect my placement and treatment for with an appropriate provider.

☐ HMIS and designated housing provider.

By signing this authorization, I am attesting that I understand:

☒ I can be placed on a centralized, network-wide waitlist that can be viewed by Broward Behavioral Health Network (BBHC), Carisk Partners and all BBHC-affiliated providers.

☒ My protected health information, including my Mental Health, Drugs & Alcohol and HIV/AIDS information (if applicable), can be shared with BBHC-affiliated providers and/or HMIS participating organizations who may provide services to me.

☒ The providers that have access to my protected health information, including my Mental Health, Drugs and Alcohol and, if applicable, HIV/AIDS information, are prohibited from re-disclosing this information without my written authorization, except as permitted by federal or state law.

☒ I may revoke this consent at any time; however revocation will not affect any disclosures already made.

Photocopy/Scanned Copy. A photocopy or scanned copy of this form will be as valid as the original.

Expiration of Authorization: This authorization will expire in 12 months or on: _________________, 20___.

Revocation of Authorization: This authorization was revoked by the client on _________________, 20___. This revocation does not affect any disclosures made in reliance on the original authorization.

Client Signature: ________________________________ Witness Signature: _______________________________

____ _________________________

Signature of Client or his/her Personal Representative Date

____ _________________________

Signature Witness Date

Rev. 11/2018