MHNet
BEHAVIORAL HEALTH

Authorization to Release Confidential Information

As I have attested below, I_____ (name / health plan ID Number) authorize MHNet, its representatives and/or _____(provider/ additional party name) to release the below specific information about me.

☐ Yes ☐ No HIV/AIDS-related information, diagnosis and test results
☐ Yes ☐ No Mental Health Information
☐ Yes ☐ No Substance Abuse Information

The information received may be released to the following:

Party One	**Party Two** (if more than two parties use add'l. release)
_____ Name	_____ Name
_____ Street Address	_____ Street Address
_____ Address (City, State, Zip)	_____ Address (City, State, Zip)
_____ Telephone Number	_____ Telephone Number
_____ Company/Title	_____ Company/Title

The following information is requested for release to the above parties:

☐ All clinical and administrative records maintained by MHNet
☐ Case Management records
☐ Authorization records (includes information submitted by my providers)
☐ Claims records
☐ Call Tracking records
☐ Other specific information: _____
_____

Please release records from the following time frame: ☐ _____ to _____ or ☐ ALL

This authorization becomes effective_____(date) and may be revoked by me in writing at any time, except to the extent of action already taken. Unless earlier revoked by me, this authorization terminates twelve (12) months from the effective date. I understand that:

- MHNet may release the information authorized by this release to the authorized recipient(s) only, for the purpose(s) noted above.
- I know that I, or my authorized representative has a right to request a copy of this authorization.
- I may be charged a reasonable fee for copying, depending on the number of records.
- I have the right to look at the information that is being shared.
- Third parties who receive this information could share it with others.
- I have the right to refuse to sign this form. If I do not sign this form, MHNet may not share this information for the purposes above.

_____ _____
Legal Signature of Client or Legal Guardian Date

_____ _____
Name of Client (please print) Signature of Witness

Notice to Recipient: This information has been disclosed to you from the records protected by Federal confidentiality rules (42 CFR Part 2) and/or state law. In accordance with federal and state law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further redisclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.