SERV Behavioral Health System, Inc.

Authorization to Release/Obtain Protected Health Information

Individual Name: _____ SERV ID #: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

I authorize SERV Behavioral Health System, Inc. (SERV) to (Check one or both):

❒Release Information To **❒Receive Information From**

_____ _____ _____

Organization or Individual Name Telephone Number Fax Number

_____

Street Address City State Zip Code

Description of Information to Be Released (Initial by all that apply):

_____ Individual Fact Sheet
_____ Service Plan/ Individualized Habilitation Plan
_____ Assessment/Evaluation including diagnosis
_____ Nursing Assessment (s)
_____ Description of services/interventions and response
_____ Medical Examination including medical diagnoses
_____ Minimum necessary information for Benefits
_____ Medication Records
_____ Other: _____
_____ Other: _____

Specific Confidential Information Authorized for This Release (Initial by all that apply):

By signing my initials next to the specific category of highly confidential information, I am authorizing SERV Behavioral Health System, Inc. to release the indicated type of information next to my initials.

_____ HIV/AIDS Related Information
_____ Drug and Alcohol Information
_____ Psychotherapy Notes (Outpatient and Partial Care)
_____ Tuberculosis Information
_____ Genetic Information
_____ Sexually Transmitted Disease Information

Purpose of Release:

_____ To coordinate treatment & services
_____ To determine appropriateness for placement
_____ To obtain or continue benefits
_____ To involve family members in services & planning
_____ Other: _____
_____ Other: _____

Mark all types of communication permitted: ❒Mail ❒Telephone/Verbal ❒Fax ❒Electronic Communication

Please Send the Requested Information To:

(This section is to be completed if requesting written/printed protected health information from outside of SERV)

SERV Behavioral Health System, Inc.

_____

Street Address

_____

City State Zip Code

Attention (SERV Staff Person): _____

(Over)

Term/Expiration:

I wish this authorization to have the following expiration **(<u>Initial</u> your choice below**)

____ This authorization will expire on this date: _____ (not to exceed 5 years from today)
____ This authorization will expire when I discontinue services with SERV Behavioral Health System, Inc., or in exactly 5 years from the date I sign this form, whichever comes first.

I understand that I will be given the opportunity to review the Authorization at any time upon my request, or at least once a year for any Authorization with a longer period of validity.

The information to be disclosed from my records is confidential and is protected by federal and state law. I understand that once SERV releases my health information to the recipient listed on this authorization, SERV cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal or state law governing the use and disclosure of my health information.

I understand that SERV may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written revocation to SERV. The revocation will be effective immediately upon SERV's receipt of my written notice, except that revocation will not have any effect on any action received/transmitted prior to the revocation.

I have read and understand the terms of this authorization and I have had the opportunity to ask questions about my rights to access my health information and any protected health information that
SERV uses to make treatment decisions about me. I also understand that if I have further questions or concerns regarding my protected health information, I may contact the SERV Director of Quality and Compliance at:

Director of Quality and Compliance
SERV Behavioral Health System, Inc.
20 Scotch Road, Ewing, New Jersey 08628
Telephone Number: (609) 406-0100 x3090, Fax Number: (609) 406-0307

A copy/reproduction of this form shall be considered the same as the original.

I hereby authorize SERV to release/obtain the health information listed on the front side of this form for the purposes described in this authorization.

Individual Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If the individual is a minor or otherwise unable to sign this authorization then obtain the signature from the authorized representative below.

Personal Representative Signature: _____ Date: _____

Description of Personal Representative's authority to act on behalf of the individual): _____
_____