Concordia BEHAVIORAL HEALTH

Broward Behavioral HEALTH COALITION

Authorization for Release of Protected Health Information for Waitlist Participation

Client Name				Client Social Security Number
Street Address				Client Date of Birth
City	State	Zip Code		Phone Number

I authorize	Name of Provider Referring Client to Waitlist			
	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 Network (BBHC),
  Concordia Behavioral Health, and
- ☐ All BBHC-affiliated providers-Florida State Hospitals.

for the purposes of:

- ☐ Listing me on a secure, centralized, network-wide waitlist,
- ☐ Decreasing the length of time I have to wait for services I need, and
- ☐ Improving coordination of my care among network providers.

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.

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), Concordia Behavioral Health (CBH) 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 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

02.18.2015, Rev. 06.15.2015