Aurora Behavioral Health Care **AUTHORIZATION FOR RELEASE OF RECORDS**

NAME OF PATIENT:_____ PATIENT'S BIRTHDAY:_____

I hereby authorize Aurora Behavioral Health Care/CHARTER OAK HOSPITAL, its agents, employees, and/or servants to disclose my psychiatric and/or substance abuse records, and information obtained in the course of my diagnosis and treatment at this facility to:

_____ _____(____)_____(____)_____

AGENCY/FACILITY/PHYSICIAN/SCHOOL ATTENTION OF Phone # Fax #

_____ _____

STREET CITY/STATE/ZIP CODE

FOR THE FOLLOWING PURPOSES:

☐ CONTINUING CARE BY THE RECEIVING FACILITY/DOCTOR/THERAPIST

☐ LEGAL PROCEEDINGS OR ADVICE ☐ ASSISTANCE BY THE ABOVE NAMED AGENCY

☐ ARRANGE FOR RESIDENTIAL TREATMENT ☐ EDUCATION PLANNING

☐ OTHER: _____

SUCH DISCLOSURE SHALL BE LIMITED TO THE FOLLOWING SPECIFIC INFORMATION:

☐ FACE SHEET ☐ PSYCHIATRIC HISTORY AND MENTAL STATUS EXAM

☐ DISCHARGE SUMMARY ☐ LAB AND X-RAY REPORTS

☐ AFTERCARE PLANS ☐ MEDICATION RECORDS

☐ TREATMENT PLANS ☐ "MY MEDS" RECORDS

☐ MEDICAL HISTORY AND PHYSICAL EXAM

☐ OTHER (SPECIFY): _____

This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance thereon and if not earlier revoked it shall terminate one year from the date of signing.

Release of transfer of the disclosed information to any person or entity not specified herein is prohibited by law. An additional consent must be obtained for further usage or transfer of disclosed information.

I am fully aware that certain State and Federal Statutes and Regulations require that I voluntarily and knowingly sign this document before Aurora Behavioral Health Care can release any records, and that I may refuse to sign my signature, but in that event the record cannot and will not be released or disclosed by Aurora Behavioral Health Care.

Dated: _____ Time: _____ _____ (_____)_____

SIGNATURE OF PATIENT TELEPHONE #

I have received a copy of this authorization. Patient Initial: _____

Dated: _____ Time:_____ _____

SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE OF PATIENT (indicate which)

Dated:_____ Time:_____ _____

Witness

Dated:_____ Time:_____ _____

SIGNATURE OF PHYSICIAN/THERAPIST (when applicable)