CREATIVE BEHAVIORAL CONNECTIONS
creating connections to last a lifetime

5803 W. Craig Road, Suite 105, Las Vegas, NV 89130
Phone: 702-901-5200 Fax: 702-901-5201

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By completing this form, I, or my legal representative, agree to allow the sharing of my Protected Health Information (PHI) with the people or agencies identified below.

Client's Name:_____ Date of Birth:_____
Address:_____
Phone Number:_____ Social Security Number:_____

I request and authorize the release of healthcare information of the above named client:

Send Records □ TO □ FROM:	**Send Records □ TO □ FROM:**
Creative Behavioral Connections 5803 W. Craig Road, Suite 105 Las Vegas, NV 89130 P: 702-901-5200 F: 702-901-5201	Name:_____ Address:_____ _____ Phone:_____Fax:_____

Purpose of Release:

□ Treatment/ Continued Care □ Personal Use □ Legal □ Disability Determination □ School
□ Other:_____

Information To Be Released:

□ Entire Record □ History and Physical □ Psychological Evaluation □ Psychiatric Evaluation
□ Progress Notes □ Discharge Summary □ Immunization Records □ Past/Present Medication
□ Other (Specify):_____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Results/Treatment

Effective Time Period: This authorization is valid until the earlier of the occurrence of death to the individual; the individual reaches the age of majority; or permission is withdrawn; or the following specific date:_____.

Right to Revoke: I understand that I can withdraw my authorization at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Send Records To". I understand that prior actions taken in reliance on this authorization by entities that had permission to access my PHI will not be affected.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information described. I understand that refusing to sign this form does not stop disclosures of PHI that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by 45 CFR 164.502. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____
Client, Parent/Legal Guardian Signature Date

_____ _____
Print Name Relationship to Client