



Behavioral Health Release of Medical Information

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name (if applicable): _____ Relationship to patient: _____

I authorize The Family Connection, LLC to use and disclose the protected health information as indicated below:

- All health records related to drug/alcohol/substance abuse
- All health records related to emotional/mental/developmental disabilities/psychiatric conditions **(excludes psychotherapy notes)**
- Other: _____

Release of medical information from/to The Family Connection LLC to/from:

Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that this medical information may be used by the person I authorize for the purpose of medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I may cancel this authorization, in writing, at any time. I understand that my health care providers may have already released records according to this authorization prior to receiving my notice of cancellation. I understand that this will remain in effect until the end of treatment unless a date of expiration is indicated here: _____

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that this information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Date