Ascent Neurobehavioral Institute

Authorization for Use or Release of Information

Page One of Two

I hereby authorize: ☐ ***Ascent Neurobehavioral Inst.*** ☐ ***Other (Specify)***

(Check One)

540 West Plumb Lane, Ste 1A
Reno, NV 89509
Phone (775) 322-4666
Fax (775) 322-4747

Name:_____
Address:_____
_____
Phone:_____

To use or release health information and records obtained during the course of treatment of:

Patient Name:_____ Date of Birth:_____
Address:_____ Patient's Phone:_____
_____ Social Security #:_____
Date of Death:_____

1. The information is to be used or disclosed to the following person or organization:

Person / Entity Name: _____
Address: _____
Phone Number(s): _____
Fax Number(s):_____

2. Purpose: The purpose of this disclosure is:

☐ At the request of the patient / or parent / guardian

☐ Other (Specify): _____

3. Information to be used or disclosed:

The information to be used or disclosed includes only those items checked below, with respect to services provided on or around (insert dates of service): _____. If this line is left blank, the treatment dates covered by this authorization are from date of initial exam to termination of care and claims resolution.

I understand that this authorization extends to all or any part of the records / information designated below which may include treatment for physical and psychiatric / mental illness, alcohol / drug abuse, HIV / AIDS test results or diagnosis. The information to be used or disclosed includes:

☐ Demographics / Face Sheet
☐ Initial Psychiatric interview / exam
☐ Medication Records
☐ Diagnosis
☐ Verbal Communication with:
Name:_____
Relationship:_____

☐ Laboratory Orders / Results
☐ Progress / Psychotherapy Notes
☐ Billing Financial Records
☐ Contact History / dates of service
☐ Other (Specify):_____
_____
_____

Ascent Neurobehavioral Institute

Authorization for Use or Release of Information

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Patient's Name:_____

This authorization is limited to only the information that I have requested on page one to be used or disclosed to the persons / facilities named herein.

I hereby release ***Ascent Neurobehavioral Institute*** from all legal responsibilities of liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

If the patient is a minor, relevant state law should be followed with respect to the required signatures. ***Ascent Neurobehavioral Institute*** will not condition treatment, payment or eligibility for benefits on whether this authorization is signed.

1. **Expiration:** I understand that unless I revoke the authorization earlier, this authorization will automatically expire 180 days, or according to the relevant state law, from the date of this authorization.
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by Federal law, and could be used or re-disclosed by the receiving party.
3. **Refusal to Sign:** I understand that I may refuse to sign this authorization and that ***Ascent Neurobehavioral Institute*** will not condition treatment on whether I sign this authorization.
4. **Certification:** I certify that I am (check whichever applies):

   ☐ **The patient, and the identification that I have provided is true and correct**

   ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided is true and correct. My relationship to the patient is that of:_____
5. **Revocation:** I have the right to stop the use or disclosure of information at any time, although I understand that I cannot do anything about the information already used or disclosed under this authorization.
6. **Copy:** I understand that I will receive a copy of this completed form.

_____ _____

Patient's Signature Date

_____ _____

Parent / Guardian Signature Date

_____ _____

Staff Member / Witness Signature Date