

**SPRINGWOODS BEHAVIORAL HEALTH**

1955 Truckers Drive  
Fayetteville, Arkansas 72704  
479-973-6000

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

I hereby authorize Springwoods Behavioral Health to release medical/ mental health information to:

\_\_\_\_\_  
Name of person or facility to receive information

\_\_\_\_\_  
Mailing address, City, State, Zip Code

Information to be released:

- History and Physical
- Psychological Assessment
- Treatment Plan
- Progress Letter
- Verbal Exchange for Coordination of Educational Services
- Other -Specify \_\_\_\_\_
- Verbal exchange only
- Psychiatric Assessment
- Discharge Summary
- Nursing Assessment
- Crisis Safety Plan
- Verbal exchange only for acknowledgement of assessment and/or disposition
- Medication Records
- Progress Notes
- Aftercare Plan
- Educational Records

For the following purpose:

- Continuing medical treatment
- Insurance purposes
- Other – Specify \_\_\_\_\_

For the treatment date(s): \_\_\_\_\_

This authorization shall include the release of alcohol and/or drug related information as provided for under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act Amendment of Public Law 93-282. I understand that I may revoke this consent to release health information at any time in writing, but that any revocation is not effective for disclosures that have already been made. I understand that, except as otherwise limited by law (42CFR Part 2), the information disclosed pursuant to this authorization is potentially subject to redisclosure by the recipient, and, upon receipt, is no longer protected or limited by this authorization. A photo static copy of this authorization shall be as valid as the original. I understand that Springwoods Behavioral Health does not condition my treatment on the receipt of an authorization, except when necessary for research related treatment or creating health information specifically requested by me for disclosure to a third party. The undersigned hereby authorizes the transmission of the requested information by facsimile and releases and holds Springwoods Behavioral Health harmless from any damages, causes of action or liability which may result from any improper transmission or in the event that the transmitted information reaches any unauthorized person. This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested PHI is disclosed, the PHI's recipient may redisclose it, therefore the Privacy Regulations may no longer protect it.

The information I authorize for release may include information that could be considered information about communicable or venereal diseases which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

This authorization expires 90 days from the date signed below and covers only treatment for the dates specified above.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Signature