Authorization to Use and Disclose Protected Behavioral Health Information

I authorize the release of my behavioral health information to my Primary Care Physician for purposes of coordinating my health care. I understand that as a result of this authorization, the behavioral health information disclosed pursuant to this authorization will become a part of my general medical record and thereby may be subject to redisclosure.

I understand that my Behavioral Health records are protected under the applicable state law governing health care information that relates to mental health services. They may also be protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CRF Part 2).

I also understand that I may revoke this consent at any time (in writing) except to the extent that action has been taken in reliance on it. To revoke this authorization, please provide a written statement to the Kaiser Permanente Behavioral Health Department. Kaiser Permanente may not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization. **FOR INSURANCE CONTRACTS ISSUED IN THE COMMONWEALTH OF VIRGINIA OR DISTRICT OF COLUMBIA**: I understand that this authorization shall be valid: (a) in the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits: (1) Thirty months from the date the authorization is signed If the application or request Involves life, accident and sickness, or disability insurance; (b) in the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy: (1) the term of coverage of the policy if the claim is for an accident and sickness insurance benefit; (2) the duration of the claim if the claim is not for an accident and sickness insurance benefit.

This authorization will automatically expire twelve months from the date signed. I may obtain a copy of this authorization upon request. A copy of this authorization will be sent with my records to my Primary Care Physician. I also understand that I am entitled to inspect my records.

I AUTHORIZE:
Kaiser Permanente
Behavioral Health Department

TO RELEASE TO: My Primary Care Physician & Health Care Team
Mid-Atlantic States Permanente Medical Group and
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Or Network Provider: _____
Print Provider's Name

The following portions of my Behavioral Health chart:

☐ Diagnosis ☐ Chemical Dependency Diagnosis & Treatment Information
☐ Treatment Plan ☐ Medication ☐ Other _____

☐ I understand that the Behavioral Health information being released pursuant to this Authorization will become part of my general medical record and may be subject to re-disclosure.

Signature _____ Date_____

If other than patient, indicate relationship: _____

MRN: _____ D.O.B _____

Patient/Guardian _____ Date:_____
(Signature)

If other than patient, indicate relationship: _____

TO THE PERSON(S) RECEIVING RECORDS: If this authorization pertains to alcohol or drug information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.