BRONSON	Affix Patient Label
	Patient Name: DOB:

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION
Bronson Healthcare

This form cannot be used for a release of information from any person or agency that provided services for domestic violence, sexual assault or stalking. A separate consent must be completed with the person or agency that provided those services.

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or group can use and share most of your health information. Information is used to provide you with treatment receive payment for care and manage your care. Your consent is needed to share certain types of health information. This form lets you give consent to share information about:

- Behavioral and mental health services
- Treatment for alcohol and substance use disorder

This information is shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information.

_____

_____

_____

I consent to share:

☐ All of my behavioral health and substance use disorder information

OR

☐ All of my behavioral health and substance use disorder information except:

(List types of health information you do not want to share below)

_____

_____

_____

_____

I consent to share my information with the following:

Name: **phone:** **fax:**

1. _____
2. _____
3. _____
4. _____
5. _____

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By signing this form I understand:

- I am giving consent to share my behavioral health and substance use disorder information. Information I do not want to share is listed above. My information may be shared with each agency and person listed above.
- My information will be shared to help diagnose, treat, manage and pay for my health needs.
- My consent will not affect my ability to get mental health or medical treatment, payment for treatment, health insurance or benefits.
- My health information may be shared electronically.
- The law allows my providers and other agencies to use and share most of my health information without my consent to provide me with treatment, receive payment for my care, and to manage my care.
- The sharing of my health information will follow state and federal laws and rules.
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- I can end my consent at any time. Any information that has already been shared cannot be taken back.
- I should tell all agencies and people listed on this form when I end my consent.
- I can have a copy of this form.
- I understand this authorization will expire in one year from date signed.
    - o I can cancel this authorization at any time.

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Patient Signature_____Date:_____Time:_____

Relationship: ☐Patient ☐Closest relative (relationship)_____ ☐Guardian

TO BE KEPT AS PART OF THE PERMANENT RECORD

BRONSON

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WITHDRAWING CONSENT

I understand that any information already shared cannot be taken back.

I withdraw my consent to share my health information:

☐ Between any of the following persons or agencies:

_____ _____

_____ _____

_____ _____

OR

☐ For all persons and agencies:

Signature of person giving consent or legal representative:

_____ Date:_____ Time:_____

Relationship to individual

☐ Self-Representative ☐ Parent ☐ Guardian ☐ Authorized

Verbal Withdrawal of Consent

This consent was verbally withdrawn.

Signature of person receiving verbal consent:

_____ Date:_____ Time:_____

☐ Individual provided copy ☐ Individual declined copy