Aroga Behavioral Health of Princeton

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION

1. **Internal (within Aroga Behavioral Health)**

I, (print name) _____, understand that Aroga Behavioral Health is a group practice which operates on a team-based treatment model and that, upon entering into treatment with any healthcare provider within said group, information about my treatment may be shared/exchanged with any other healthcare provider employed by or contracted by said group during the course of my treatment. I understand that such sharing of information within the group is for the sole purpose of facilitating my treatment. Examples would include but not be limited to my psychiatrist communicating with my therapist and vice versa about my treatment, or a psychiatrist or therapist providing coverage during absence of my regular provider(s). I give full consent for my psychiatrist and/or therapist as members of Aroga's group practice to share information about my treatment with each other for the purpose of facilitating my treatment. I understand that under no circumstances shall any provider within the group share information about me or my treatment with any individual or organization outside of the group except where I have authorized below and/or in accordance with the HIPAA privacy policies I have been separately provided with.

2. **External (outside of Aroga Behavioral Health)**

In addition to the above, I hereby authorize Aroga Behavioral Health, and therefore my psychiatrist(s) and/or therapist(s) employed by or contracted by Aroga Behavioral Health, to release information about me and treatment to the following individuals and/or organizations:

PRIMARY CARE PHYSICIAN:

Name:_____

Address:_____

_____

Phone #:_____

Fax #_____

THERAPIST (Outside of Aroga's Group):

Name:_____

Address_____

_____

Phone #_____

Fax #_____

OTHER:

Name:_____

Rel. to patient:_____

Address:_____

_____

Phone #:_____

Fax #_____

OTHER:

Name:_____

Rel. to patient:_____

Address_____

_____

Phone #_____

Fax #_____

With reference to all of the above, I understand that this information is not to be re-released to any person or facility except as provided by law. This release will continue in effect until termination of my treatment unless I specify another termination date here: _____. I understand that I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. To the extent that my record includes information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I am also authorizing disclosure of such information.

X_____ _____ _____

Signature of Patient *or* Parent/Legal Guardian *or* Health Care Agent — Date — Signature of Witness

Print Name _____ **Print Name**_____