Cumberland Mountain Community Services Board (CMCSB)
Authorization for Use/Disclosure/Exchange of Protected Health Information from a Third Party

I: _____
Full Legal Name DOB SSN

hereby authorizes: ☐ Cumberland Mountain Community Services Board
☐ The Laurels Recovery Center
☐ Residential Recovery Services (The Laurels Crisis Stabilization Unit)

Address: _____

Telephone #: _____ FAX #: _____

to disclose/obtain/exchange the following information: (Please check the box or boxes that apply)

☐ *Mental Health* ☐ *Substance Abuse* ☐ *Intellectual Disabilities / Developmental Disabilities*

☐Diagnostic Reviews ☐Progress Notes ☐ Crisis Stabilization – Residential ☐Crisis Stabilization – Community
☐Lab Results ☐ISPs ☐Quarterly Reviews ☐Assessments ☐Screenings
☐Discharges/Case Closures ☐Psychological Evaluation ☐Medical Information ☐Psychiatrist/NP Notes ☐ Other (list below)

_____

To the following Recipient:

Name of Person and Organization: _____
Address: _____
City/State/Zip: _____
Telephone #: _____ FAX #: _____

Purpose of Use/Disclosure/Exchange:
☐ to assist in diagnosis, consultation, coordination of care and/or treatment
☐ other (be specific) _____

I understand that I am giving my permission to the persons/organization above-named for the disclosure of protected health information contained in my mental health, developmental services, and/or substance abuse records. I also understand that I have the right to revoke this authorization at any time, except to the extent that action has been taken based on this authorization, by sending a written revocation of authorization to Cumberland Mountain Community Services, Attention: Medical Records, P. O. Box 810, Cedar Bluff, VA 24609.

This authorization is limited to a single use/disclosure/exchange: ☐ Yes ☐ No If 'No'; this authorization will expire in
☐ One Year – or – (specify a date or event): _____
unless revoked by me (in writing) prior to that date, event or condition.

This authorization ☐ INCLUDES ☐ DOES NOT INCLUDE information placed in my record after the date signed.

Is there any information that you do not want released? ☐ Yes ☐ No If yes, please list :

_____

As the person signing this authorization, I acknowledge that I am giving permission to CMCSB to disclose/obtain/exchange PHI. I further acknowledge that:

- I may refuse to sign this authorization.
- CMCSB cannot condition the provision of treatment on my signing this authorization.
- I understand there is a potential for any information used/disclosed/exchanged pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule.
- I understand that if my records are protected under Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), they cannot be disclosed without my written authorization unless such disclosure is otherwise permitted by law. This includes information concerning HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses which may be controlled by various laws and regulations. A general authorization for the disclosure/release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I consent to disclose of such information.
- I understand that this information will be shared with those individuals in the criminal justice system who have a need for the information in connection with their duty to monitor my treatment.
- I further acknowledge that the information to be disclosed was fully explained to me and this authorization is given of my own free will. A copy of this authorization may be accepted in lieu of the original.

Individual and/or Parent/Guardian/AR was given a copy of this authorization: ☐ Yes ☐ Declined

DO NOT SIGN THIS FORM UNLESS ALL SECTIONS ARE COMPLETE AND YOU AGREE THAT IT IS ACCURATE

Individual's Signature:		Date Signed :	
☐ **Authorized Representative** ☐ **Guardian** ☐ **Parent** Signature:		Date Signed:	
Minor's Signature: (if required by law)		Date Signed:	

CMCSB is a non-profit organization. If there is a charge for medical records, please contact us at 276-964-6702 prior to sending any info.