Aurora
Behavioral Health Care

AUTHORIZATION FOR RELEASE OF RECORDS

NAME OF PATIENT: _____ **PATIENT'S BIRTHDAY:** _____

I hereby authorize Aurora Behavioral Health Care/Las Encinas, its agents, employees, and/or servants to disclose my psychiatric and/or substance abuse records and information obtained in the cause of my diagnosis and treatment at this facility to:

_____ _____
AGENCY/FACILITY/PHYSICIAN/SCHOOL ATTENTION OF

_____ _____
STREET CITY/STATE/ZIP CODE

FOR THE FOLLOWING PURPOSES:

- ☐ CONTINUING CARE BY THE RECEIVING FACILITY/DOCTOR/THERAPIST
- ☐ LEGAL PROCEEDINGS OR ADVICE
- ☐ ASSISTANCE BY THE ABOVE NAMED AGENCY
- ☐ ARRANGE FOR RESIDENTIAL TREATMENT
- ☐ EDUCATIONAL PLANNING
- ☐ OTHER: _____

SUCH DISCLOSURE SHALL BE LIMITED TO THE FOLLOWING SPECIFIC INFORMATION:

- ☐ DISCHARGE SUMMARY
- ☐ PSYCHIATRIC HISTORY & MENTAL STATUS EXAM
- ☐ MEDICAL HISTORY & PHYSICAL EXAM
- ☐ RESULTS OF PSYCHOLOGICAL TESTS
- ☐ LAB & X-RAY REPORTS
- ☐ EDUCATIONAL ASSESSMENT AND REPORTS
- ☐ TREATMENT PLANS & UPDATES
- ☐ CONSULTATIONS

OTHER (SPECIFY): _____

This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance thereon and if not earlier revoked, it shall terminate one year from the date of signing.

Release or transfer of the disclosed information to any person or entity not specified herein is prohibited by law. An additional consent must be obtained for further usage or transfer of disclosed information.

I understand that I have the right to receive a copy of this authorization if I so request.

I am fully aware that certain State and Federal Statutes and Regulations require that I voluntarily and knowingly sign this document before Aurora Behavioral Health Care can release any records, and that I may refuse to sign my signature, but in that event, the record cannot will not be released or disclosed by Aurora Behavioral Health Care.

Dated: _____ Time: _____ _____
SIGNATURE OF PATIENT

Dated: _____ Time: _____ _____
SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE OF PATIENT (indicate within)

Dated: _____ Time: _____ _____
WITNESS

Dated: _____ Time: _____ _____
SIGNATURE OF PHYSICIAN/THERAPIST (when applicable).

SEE REVERSE SIDE FOR INFORMATION REGARDING INFORMED CONSENT

Authorized Agent:
Knox Attorney Service, Inc., Knox Services LLC.