Authorization for the Release of Confidential Information

Client Name: _____ Date of Birth: _____/_____/_____

This Authorizes: Herndon Consulting, LLC dba BeMeBetter Phone: 505-293-2881 Fax: 888-506-2110

To Release Information To: _____

(Facility, organization, individual receiving information)

_____

(Telephone, fax number, address)

___ I authorize Herndon Consulting, LLC dba BeMeBetter to have contact with and release medical records to the above named.

I specifically authorize the release of my medical records to include the following records (initial):

_____ HIV / AIDS results and treatments
_____ Sexually transmitted or "communicable" disease information
_____ Prescription Drug Information
_____ Drug, alcohol, or substance abuse information
_____ Mental health information (other than psychotherapy notes)

___ **I do not authorize** Herndon Consulting, LLC dba BeMeBetter to release medical records.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken upon this authorization, by sending the health providers a cancellation notice in writing. **I further understand that this authorization shall expire without my express revocation one year from the date of the signature.** I understand I may have a copy of this authorization upon my request. I understand that the agency which receives this information will be notified not to redisclose this information without further written consent. However, once the information is disclosed by Herndon Consulting, LLC DBA BeMeBetter, the recipient may lawfully or unlawfully redisclose information beyond Herndon Consulting, LLC DBA BeMeBetter's control. I am also aware I have the right to inspect and receive a copy of the disclosed Protected Health Information unless the disclosure is deemed unlawful or not in my best interest. By my signature below, I attest I have been fully informed of my rights and hereby consent to and authorize the disclosure.

_____	_____	_____
(Client's Signature if 14 years or older)	(Client's Signature if 14 years or older)	(date)
_____	_____	_____
(Signature)	(Relationship)	(date)
_____	_____	_____
(Witness)	(Printed name)	(date)

If the patient is legally competent, the client must sign this form. If the client is competent, but unable to sign, the client's mark of consent may be witnessed. If the client is legally incompetent, the form may be signed by the guardian or conservator only. If the client is a minor, a parent may sign.

Notice to recipient agency

Mental health information and medical records are disclosed pursuant to this written authorization by the client or the client's legal representative. Recipients of this information may not disclose the information except as specifically authorized. Any unauthorized disclosure of mental health information is unlawful and may result in civil damages and/or criminal penalties under state and federal law.

(HIPAA, HITECH, and Omnibus compliant form revised and adopted 7/25/2015)