Imagine Behavioral Health ⚬ 1855 Lakeland Drive Suite R-305 ⚬ Jackson, MS 39216 ⚬ 601.982.5376 ⚬ 601.982.5377 Fax

RELEASE OF CONFIDENTIAL INFORMATION FORM

I, _____, whose date of birth is __/__/____, authorize Imagine, LLC (DBA) Imagine Behavioral Health, to disclose to and/or obtain from _____ the following information:

(Patient please initial beside information to be disclosed)

____	Assessment & Diagnosis	____	Testing Information
____	Medication Management	____	Psychosocial Evaluation
____	Presence/Participation in Treatment	____	Psychological Evaluation
____	Continuing Care Plan	____	Treatment Plan or Summary
____	Other _____		

- The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:
  _____
  _____
- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Imagine, LLC, at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.
- Unless sooner revoked, this authorization expires on _____, or as otherwise indicated:
  _____
- I further understand that Imagine, LLC (DBA) Imagine Behavioral Health will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
  _____
  _____
- Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse and/or mental health treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

_____
_____

I will be given a copy of this authorization for my records.

_____ _____

Signature of Client **Date**

_____ _____

Signature of Parent, Guardian or Personal Representative **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual:

_____

_____ _____

Signature of Staff Witness **Date**