TurnKey
HEALTH

AUTHORIZATION FOR DISCLOSURE AND RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: Jason Lynch **ID#/DOB:** 10·07·82 **Facility:** White County

I hereby authorize the use or disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following (please provide complete address):

Name of Facility or Person to receive PHI:
White County Detention Center
Address: 1100 E. Booth Road
Phone no.: 501-278-8050
Fax no.: 501-278-8058

Name of Facility or Person to Release PHI:
Baptist Health-
Address: NLR
Phone no.: 501-202-4725
Fax no.: 501 202 4745

The type of information to be disclosed: Last Visit only

Evaluations ✓
Diagnosis ✓
Treatment Plan ✓
X-ray reports ____
Medical/Hospital Records ✓
Psychological Test Results ✓
Medical Test Results ✓
Lab results ✓
Medications ____
Mental Health Record Summary ✓
Psychotherapy Notes ____
Domestic Violence Information ____
Sexual Assault Information ____
Pregnancy Test Results ____

The purpose of such disclosure:

Ongoing Treatment ✓ Medical Care ✓ Consultation ____
Evaluation ____ Transfer ____ Coordination of Care ✓

The designated information about me ✓ may ____ may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. The above designated person ✓ may ____ may not discuss by telephone the content of the information released.

This consent is in effect until release from custody. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that the information authorized for release may include records related to mental health, or drug, substance, or alcohol abuse. I also, understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in **section 12.43.218 CRS** and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

I understand that information I have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the U.S. Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the U.S. Department of Health or by law.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Signature of Patient: Jason M Lynch **Date:** ____

Signature of Parent/Guardian: ____ **Date:** ____

Witness Signature: [illegible] **Date:** 7·18·24

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

Revised 12/16/20

TRANSMISSION VERIFICATION REPORT

TIME : 07/18/2024 04:09PM
NAME :
FAX :
TEL :
SER.# : U67266M3N455110

DATE,TIME	07/18 04:08PM
FAX NO./NAME	5012024745
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