GUAM BEHAVIORAL HEALTH & WELLNESS CENTER
790 Governor Carlos G. Camacho Rd., Tamuning, Guam 96913
Tel: (671) 647-5343 Fax: (671) 647-0191

GBHWC AUTHORIZATION TO RELEASE MENTAL HEALTH RECORDS

Purpose: This form is used when you want information from your mental health record to be released to yourself or someone else. Once you complete and sign this form, the information you identify on this form will be prepared and released. This form is not completed for releases already addressed in the Notice of Privacy Practices (i.e., for treatment, payment, and daily operations).

Hours for requesting and picking up records: Monday- Friday 8:00 AM to 5:00 PM, excluding Government of Guam holidays.

Length of time to process requests: Once the request is approved, GBHWC will prepare the documents within 5-30 calendar days, with a few exceptions. Please understand we **do not** release records on the same day we receive your request, so make sure you make your request at least five (5) days prior to needing the records. If you do not receive your request within 30 calendar days, please call our Medical Records Office at (671)-647-5343 to follow up.

Requirements for picking-up records: The person picking up the records must provide picture identification prior to the release of the records; this also applies to consumers picking up their own records.

Denying requests: The clinician who was/is in charge of the consumer's treatment may deny the request in limited circumstances. We will notify the requestor and inform them how to appeal a denial. If your request is denied, we will notify you within 30 calendar days. If the request is denied, a clinician may prepare a summary instead of allowing access to the requested information, as long as the requestor agrees to the summary alternative.

Summary Alternative: If you are requesting a lot of information for your personal records we suggest you ask for the summary alternative. This option is best if you would like an easy to understand explanation of your treatment rather than attempting to understand the clinical terms commonly found in mental health records. If you want this alternative, you will **not** receive copies of your record; instead you will receive a written summary by a clinician. This option usually takes 10-30 calendar days. If you would like this option, notify the medical records staff.

Releasing entire records: We only release a consumer's entire record when it is specifically justified as the amount that is reasonably necessary to accomplish the intended purpose.

HIPAA: This Authorization form is HIPAA compliant.

Question: If you have questions about this Authorization form or the process of releasing your records, please contact any staff member before signing this form.

****TURN OVER FOR INSTRUCTIONS****

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GBHWC AUTHORIZATION TO RELEASE MENTAL HEALTH RECORDS INSTRUCTIONS

All sections must be completed.

*** Sections must be completed for your request to be processed.**

1. *You must complete name, date of birth and/or social security number.
2. *You must tell us who we are disclosing the information to
3. You must tell us what program you want us to share information from and then *identify what specific information you want us to share
4. You must tell us the dates you want your information from.
   - If you want as much information as possible, we release information no more than two (2) years back from the date of signature.
   - If you do not specify a date we will only release the most recent information/form. For example, if you mark "Psychiatric Assessment" and there are multiple assessments, we will only release the most recent Psychiatric Assessment, not all the Psychiatric Assessments in your record.
5. If your record contains or might contain privileged information (i.e., substance abuse information) you must initial each line indicating the information can be included in the release. If you do not want specific privileged information released do not initial on the line(s).
6. *You must tell us how the information will be used- is it for your personal use, does another provider need it to help coordinate your care, etc.
7. *You must tell us how you want the information handled- by mail, verbally or picked up at our Medical Records Office.
   - We do not fax records (except to the social security office)
8. The Authorization will expire 1 year from the date of your signature unless you write a specific date or identify an event such as upon termination of family counseling.
9. *Please read the acknowledgement and then sign and date
   - **If the consumer is 18 years or older, the consumer *must* sign the authorization unless** the consumer has a legal representative (i.e., guardian), a disability and cannot sign the form, or the consumer is deceased. If the consumer is deceased, the surviving spouse or legal representative with legal proof must sign.
   - **If the consumer is fourteen (14) years or older** and the records being released involve treatment for mental illness, alcoholism, pregnancy, abortion, drug dependence, or AIDS/HIV/STD testing, he/she must sign.
   - **Anyone other than the consumer** who signs this Authorization must state their relationship to the consumer and provide proof of legal authority (i.e., guardianship papers) to sign on behalf of the consumer.

   If you are not known to the staff who is witnessing you complete this form, they will ask for your photo identification. This is one way we do our best to protect your confidentiality.

- Please detach and keep this information for your records.
- If you would like a copy of your competed Authorization form, please ask.

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1. *CONSUMER INFORMATION

Last Name:_____ First Name:_____ M.I.:_____

Birth Date:_____ S.S. #:_____ Former Names:_____

2. *RECIPIENT'S INFORMATION

I authorize Guam Behavioral Health and Wellness Center (GBHWC) to release information from my mental health record to the person or facility stated below:

_____

Full name of person or facility to receive the information

_____ _____

Mailing Address City, State, Zip Telephone #

3. INFORMATION TO BE RELEASED

3a. Those portions pertaining to: ☐Outpatient services ☐Inpatient Services

3b. *Check what information you want to be released:

☐Verification of Disabilities Psychiatric Summary ☐DPHSS Physicians Certification for Public Assistance

☐Diagnosis ☐Medication list ☐Case summary

☐Treatment plan ☐Transition plan ☐Discharge summary

☐All Progress Notes **-OR-**

☐Only Progress Notes by:☐Nurse ☐Social Worker ☐Counselor ☐Psychologist ☐Psychiatrist ☐Other:_____

☐All Assessments **-OR-**

☐Only Assessments by: ☐Nurse ☐Social Worker ☐Counselor ☐Psychologist ☐Psychiatrist ☐Other:_____

☐Other information (be specific):_____

4. DATES OF INFORMATION (If not specified; only the most recent information/form will be released)

Covering from (date)_____to (date)_____ **-OR-** ☐All past (up to 2 years), present & future info

5. INCLUSION OF PRIVILEGED INFORMATION

The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation 42 CFR §§2.11 and 2.13 protect the following information. If the record contains the information below, such information will only be included in this disclosure if you initial on the line. *(Initial each line)*

_____ Alcohol and/or drug abuse _____ HIV/AIDs/STD related information _____ Genetic test results

_____ Domestic violence victim counseling & sexual assault counseling _____ Pregnancy/abortion

6. *PURPOSE

☐At the request of the consumer/personal representative ☐To coordinate care ☐Obtain benefits

☐Legal ☐Other (specify):_____

7. *DELIVERY METHOD

☐ Mailed to the recipient's address above ☐Verbally

☐ Pick-up at the Medical Records Office. ****If the person on #2 is **different** from the person picking up the records, **complete the authorization below**. The information you provide below must match the information on their photo identification****

I **authorize GBHWC medical records staff to release the information to the person stated below:**

_____ _____

First and last name of person picking up the records Telephone #

***REQUIRED**

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8. EXPIRATION

This Authorization will expire one (1) year from the signature date, upon discharge from all GBHWC programs, or at the date or event stated below:

☐Specific date:_____ ☐Event: _____

9. *ACKNOWLEDGEMENT & SIGNATURE

I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization, I must do so by contacting the medical records staff. I understand the revocation will not apply to information that has already been released in response to this Authorization.

Once this information is released it is subject to re-disclosure by the recipient and is no longer protected by Federal privacy regulations. GBWHC is not responsible for unauthorized disclosure by the recipient.

I understand authorizing the release of this information is voluntary. I do not need to sign this form to receive services from GBHWC. However; lack of ability to share information may prevent GBHWC from providing necessary care.

Signature: _____ **If Representative, Title:** _____

Printed Name: _____ **Date:** _____ **Tel #:**_____

If signed by Representative: ☐ID/Proof of authority provided. **Comments:**_____

Witness Signature: _____ **Title:** _____

Printed Name: _____ **Date:** _____

OFFICIAL USE ONLY

Date rcvd:_____ **Rcvd by:**_____

DISPOSITION: ☐Approved ☐Denied *(Check all that apply below)* **by:**_____ **Date:**_____

Administrative Issues:

☐We are unable to identify this consumer. Please provide additional information (#1)
Incomplete: ☐Recipient's information (#2) ☐Information to be released (#3)
☐Purpose (#6) ☐Delivery method (#7) ☐Signature portion (#9)
☐Proof of legal authority not valid/validated

Unreviewable Grounds for Denial:

Requested info: ☐Involves psychotherapy notes ☐Compiled in anticipation of litigation ☐Not maintained by GBHWC
☐Request made by inmate of correctional institution
☐Information obtained from non-healthcare provider pursuant promises of confidentiality

Reviewable grounds for Denial:

☐The request for the entire record is not justified to accomplish the intended purpose.
☐Disclosure would cause endangerment of the consumer or another person
☐Requests made by a personal representative where disclosure is likely to cause substantial harm

Other:_____

RELEASING: MED RECORD STAFF USE ONLY

MR#:_____ **EBHR#:**_____

Ready for release on (date):_____ **Pick-up ONLY: Notified on** (date):_____

MAIL: Mailed by:_____ on (date):_____ via: ☐USPS ☐Fed Ex ☐Other:_____

VERBAL: Verbalized by:_____ on (date):_____ via: ☐In person ☐Tel ☐Other:_____

PICK-UP: Released by:_____ on (date):_____ Verified I.D.: ☐Yes ☐Other:_____

Receiver (Print):_____ Signature:_____ Date:_____

IF REVOKED: Date:_____ Signature:_____ Rcvd by:_____