The BridgeWay

www.TheBridgeWay.com | 21 Bridgeway Road | North Little Rock, AR 72113
(501) 771-1500 | Toll-Free (AR): 1-800-245-0011 | Toll-Free (National): 1-800-BRIDGEWAY

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, DOB:_____/_____/_____, SS#:_____-_____-_____
(Patients Name) (Patients DOB) (Patients SS#)
authorize The BridgeWay to disclose to/or obtain information from:_____
(Name of Person/organization)

I, the undersigned, understand that psychiatric/medical records sometimes contain references to drug/alcohol use, communicable or sexually transmitted diseases as well as Acquired Immune Deficiency Syndrome (AIDS) AND Human Immunodeficiency Virus (HIV) test results. I also understand that these records are protected by federal regulations, governing Confidentially of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent or by Court Order.

I, ___ Do ___ DO NOT consent to the release of information relating to psychiatric or psychological testing or treatment, alcohol/drug abuse testing/treatment/results and HIV (AIDS) testing/treatment/results.

☐Discharge Summary ☐Psychological Testing ☐H&P ☐Other
Other:_____

I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that in any event this consent shall expire 90 days after discharge from inpatient, outpatient, and aftercare programs unless another date is specified. A copy of this release may be used in lieu of the original.

Specifications of the date, event, or condition upon with consent expires:_____

☐ "This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under." "Once the requested PHI is disclosed, PHI's recipient may re-disclose it, therefore the Privacy Regulations may no longer protect it."

☐ This Release of Information is disclosed from records protected by Federal confidentially rules (42 CFR Part 2) (Alcohol/drug abuse treatment and the Federal rules prohibit the recipient form making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I hereby release the BridgeWay from any/all legal liability that may arise from the release of this information to the party listed above.

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Parent, Guardian, or authorized representative Date Signed

_____ _____
Signature of Witness Date Signed

Please provide the following for a more immediate response:

Phone Number:_____ Address: _____

Fax Number:_____ _____

Revised 01/2016