Hawthorn Counseling LLC

2300 S Orchard Street, Ste B, Boise, Idaho 83705; Fax: 855-249-0849

Methodist Counseling Center Mental Health Records Release Form

Patient Name: _____ Date of Birth: _____
Previous Name, if applicable: _____ Daytime Phone: _____
Approximate Dates of Service*: _____ Date Records Needed by: _____
***Patient records are kept, as required by state law, for 6 years past the final date of service. For minor patients, records are kept for 7 years past age of majority.**

I request and authorize **Hawthorn Counseling LLC (HC)**, records guardian, to **RELEASE INFORMATION** from my records at **Methodist Counseling Center (MCC)**, formerly of 4444 W Taft Street, Boise ID 83703, **TO:**
Name: _____
Address: _____
Street City State Zip
Phone: _____ Fax: _____

HC, for MCC, may disclose the following MENTAL HEALTH CARE information (check all that apply):

- ☐ Client Background/Demographic Information
- ☐ Assessment/Diagnostic Information
- ☐ Treatment Plans
- ☐ Progress/Session Notes
- ☐ Medication Lists
- ☐ Drug and/or alcohol use
- ☐ Treatment/Termination Summaries
- ☐ Billing Records
- ☐ Other _____
- ☐ Attendance Verification **only**

I understand that my mental health record includes information on the diagnosis/treatment related to psychiatric, psychological, or mental health conditions; and possibly drug and or alcohol use or abuse. If reported, the record may make mention of sexually transmitted disease, including AIDS and/or HIV status. Initial: _____

Reason for Authorization:

- ☐ At the request of the Individual;
- ☐ Other: _____

Expiration:

- ☐ Date:_____ OR ☐ Event (one time release):_____

If the date is not specified, this request will expire in 90 days from the date of signature.
If the release is for the patient's **EMPLOYER** or **FINANCIAL INSTITUTION** for reasons other than payment, this authorization will remain valid for **only 90 days.**

Patient may revoke this authorization at any time prior to expiration by notifying in writing.

The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health care informtion containing drug and alchol diagnosis and treatment, mental health, and sexually transmitted diseases are privildged and confiedential and may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may refuse to sign this authorization. The releasor or releasee may not condition treatment, payment, enrollment, or eligibility on the authorization of this release.

_____ _____ _____
Signature/Legally Responsible Party **Relationship to Patient** **Date**

A minor's signature alone is sufficient to release health care information related to (1) sexually transmitted disease including HIV/AIDS (age 14+), (2) alcohol and/or drug abuse (in Idaho, age 16+), (3) mental health information (in Idaho, age 14+).

_____ _____
Signature of Minor **Date**