Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, ID#__ _____, hereby give my authorization and permission for my "Protected Health Information" ("PHI") as indicated below to be disclosed to the following individual:

____ _____
Address: _____
Address: _____

Specific Information to be disclosed:
_____
_____
_____

Purpose of disclosure:

_____

I may be reached at the following phone number (including area code) to verify authenticity of this release: _____.

Address to which a copy of my signed Authorization form may be mailed:

_____
_____

I understand that the signed original must be mailed to CBHA and must be on file at CBHA prior to disclosure of any PHI. I understand that I have the right to review information that is being disclosed. I understand that I do not have to sign this authorization and that my refusal to sign this authorization would not affect my benefits. I have the right to revoke this authorization at any time by sending a written notice to Carolina Behavioral Health Alliance. Revoking this authorization will not have any effect on actions that Carolina Behavioral Health Alliance took in reliance on the authorization prior to receiving the revocation. **I understand that I am specifically authorizing the release of confidential information relating to drug and/or alcohol abuse.**

This is a one-time authorization that expires one year from the date of signature.

Signature:_____ Date: _____
Authorized signature Date Signed

If you have any questions, please feel free to call CBHA at (800) 475-7900.