This facility is now closed as of 12-2018, for all records requests please contact:
UHS-Nashville Regional Office
1000 Health Park Dr. Bldg. 3, Ste. 300
Brentwood, TN 37027
Phone: 615-312-5834 Fax: 615-997-1200
Email: nrorecordsrequests@uhsinc.com

The Canyon
2900 S. Kanan Dume Road
Malibu, CA 90265
(310) 457-3209

Consent/Authorization to Use or Release Protected Health Information

Section A: Must be completed for all authorizations

To prevent delay of processing your request please include a copy of your government issued photo ID (i.e. a driver's license) for signature verification.

1. Patient Name (name used during treatment) : _____

2. DOB: _____; Last four digits of Social Security Number: _____

3. I authorize The Canyon at Peace Park, LLC, 2900 S Kanan Dume Road, Malibu, CA 90265 ("The Canyon") to use and disclose the Patient's health information as follows:

(a) This Authorization applies to the following information (check *only one* of the following boxes; you must complete two of these forms if you want both psychotherapy notes and other health information released):

☐ Any and all of Patient's health (and billing) information, including, but not limited to Patient's medical history, mental health records, drug and/or alcohol abuse treatment records and/or HIV test results) other than psychotherapy notes, and EXCEPT FOR: _____
_____

-- OR --

☐ Only the following records or types of health information (check all that apply) (with the understanding that each may include information regarding the Patient's mental health, drug and/or alcohol abuse and/or HIV test results, but shall exclude psychotherapy notes)

_____Preadmission/admission documents
_____Insurance reimbursement correspondence and documentation
_____Medical history, examination reports, treatment reports/records, progress notes (may include mental health and infectious disease information, such as my AIDS/HIV status)
_____Social history, including family, education, employment, legal and drug use information
_____Summary of previous mental health and substance abuse treatment
_____Periodic reports or current treatment progress including attendance and participation
_____Laboratory/radiology reports, including TB skin test results and chest x-ray results
_____Consultation reports

_____Psychiatric and psychological records, tests, and evaluations, and test results, if kept in my medical record
_____Neurological workup
_____Disability/FMLA forms
_____Discharge and aftercare planning documents
_____All administrative documents
_____Accounting/Billing Records
_____Other specific records (specify):_____

-- OR –

☐ All psychotherapy notes may be released (including notes regarding Patient's mental health, drug and/or alcohol abuse and/or HIV test results), except for:

_____

(b) The health information identified above may be disclosed to

_____
[INSERT NAME, ADDRESS AND TELEPHONE NUMBER OF PERSON OR ENTITY WHO WILL USE INFORMATION OR TO WHOM DISCLOSURE WILL BE MADE]

(c) The recipient identified in section (b) above may use the disclosed information only for the following purposes: (check all that apply below):

_____ To develop a diagnosis, treatment and rehabilitation plan
_____ To coordinate medical and/or psychological treatment and/or social rehabilitative process
_____ To process insurance claims for services provided (diagnosis, number of visits, modalities and expected length of stay)
_____ Research
_____ Marketing
_____ Litigation
_____ Other purpose(s) (please specify): _____

4. A photostatic or electronically mailed copy hereof shall be as valid as the original authorization.

5. I understand that I have the right to revoke this Authorization in writing by providing a signed, written Notice of Revocation to The Canyon. However, the revocation will not be effective to the extent The Canyon has used or disclosed information pursuant to this Authorization before receipt of the revocation.

6. The information disclosed pursuant to this Authorization may be subject to a re-disclosure and no longer protected by the HIPAA Privacy Regulations.

7. This Authorization expires on _____ [INSERT DATE OR EVENT SO THAT AUTHORIZATION WILL NOT LAST LONGER THAN REASONABLY NECESSARY TO FULFILL THE PURPOSE OF THE RELEASE. IF THE AUTHORIZATION IS FOR RESEARCH PURPOSES ONLY, THE STATEMENT "END OF RESEARCH STUDY" OR "NONE" IS SUFFICIENT].

8. I understand that I have the right to receive a copy of this authorization.

9. Please check only one statement below:

_____ The Canyon may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Authorization is executed; OR

_____ One of the purposes of this authorization is research and The Canyon is conditioning the provision of research-related treatment on the patient or the patient's representative signing this authorization; OR

_____ If The Canyon is providing health care to the patient solely for the purpose of creating health information to release to a third party, it may condition providing the health care on the patient or the patient's representative authorizing disclosure of the health information to the third party.

10. I understand that The Canyon has elected to follow the Federal Regulations on the Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2.

Section B: Must be completed only if a health plan, a health care clearinghouse, or a health care provider has requested the authorization

1. The health plan, health care clearinghouse, or health care provider must complete the following:

Will the health plan, health care clearinghouse or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information listed above in connection with a marketing purpose? Yes____ No____

NOTE: If this Section B is completed, the Patient (or the Patient's representative if signing) must received a completed, signed copy of the authorization.

_____ _____

(Signature of Patient or Patient's personal representative) Date signed

_____

(Printed name of Patient or Patient's personal representative)

_____

If a personal representative signs for the Patient, describe the personal representative's authority to do so.