Authorization for Exchange of Information

Name of Client: _____ **DOB:** _____

Release and Receipt of Confidential Clinical Health / Educational Information

I, _____ *(legal guardian)* hereby authorize **Halo Behavioral Health** and its affiliates, employees, and / or agents, to **RELEASE** to the receiving party and its affiliates, employees, and / or agents, the protected health information of _____ *(client)*. This information may be released as photocopies, via encrypted email, and / or verbal exchange.

RELEASING PARTY	**RECEIVING PARTY**
Halo Behavioral Health	
Name of Organization	**Name of Individual / Organization**
Applied Behavior Analytic Service Provider	
Relationship	**Relationship**
15335 Morrison St. Suite 320	
Sherman Oaks, CA 91403	
Address	**Address**
(818) 856-0143	
Phone	**Phone**
info@halobh.com	
Email	**Email**

I, _____ *(legal guardian)* hereby authorize **Halo Behavioral Health** and its affiliates, employees, and / or agents, to **RECEIVE** from the releasing party and its affiliates, employees, and / or agents, the protected health information of _____ *(client)*. This information may be received as photocopies, via encrypted email, and / or verbal exchange.

RECEIVING PARTY	**RELEASING PARTY**
Halo Behavioral Health	
Name of Organization	**Name of Individual / Organization**
Applied Behavior Analytic Service Provider	
Relationship	**Relationship**
15335 Morrison St. Suite 320	
Sherman Oaks, CA 91403	
Address	**Address**
(818) 856-0143	
Phone	**Phone**
info@halobh.com	
Email	**Email**

HALO
BEHAVIORAL HEALTH

Clinical Health / Educational Information Authorized to be Exchanged

☐ **ALL** clinical health / educational information and records.

☐ **ALL** clinical health / educational information and records **EXCEPT** (please specify):

_____

_____

_____

_____

☐ **ONLY** the following clinical health / educational information (please specify):

_____

_____

_____

_____

Purpose

The purpose of the requested release and / or receipt of information

☐ Client / Legal Guardian Request

☐ Other (please specify): _____

Authorization Term and Expiration

This authorization is considered valid at the signature date and will remain in effect until:

☐ Upon Services Ending

☐ Specific Date (please specify): _____

☐ Specific Event (please specify): _____

☐ Other (please specify): _____

Rights and Regulations

I understand the following by signing this authorization:

- Halo Behavioral Health will abide by all applicable federal and state laws governing the use and disclosure of my health information.
- I may refuse to sign this authorization and understand that it is voluntary. My refusal will not affect my ability to obtain services from Halo Behavioral Health.
- I may receive a copy of this authorization.
- I may review or obtain a copy of any written health information or records that Halo Behavioral Health releases.
- I may revoke this authorization at any time and for any reason by notifying Halo Behavioral Health in writing, but acknowledge that the revocation will not have any effect on any action taken by Halo Behavioral Health based on this authorization prior to revocation.
- Halo Behavioral Health, as the releasing agency, cannot guarantee that the receiving agency will not re-disclose my information to a third party.
    - Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
    - In addition, I understand that if the entity I have authorized Halo Behavioral Health to release health information to is not a health plan or health care provider, the released information may no longer be protected by federal and / or state privacy regulations.
- Halo Behavioral Health, as the receiving agency, will maintain any received information under strict guidelines for the maintenance of confidentiality.

Signature

I have read and understand the terms of this Authorization for Exchange of Information and I have had an opportunity to ask questions about the use and disclosure of my health information. As the individual signing this authorization, I attest that I am either the client or the legal guardian of the client who is a minor or is otherwise unable to sign this authorization for him or herself. I hereby, knowingly and voluntarily, authorize Halo Behavioral Health to receive and / or release my health information in the manner described herein.

Name of Client / Legal Guardian	Relationship
Signature of Client / Legal Guardian	**Date**

To Receiving Agency: Prohibition on re-disclosure. This information has been disclosed to you from records whose confidentiality is protected by law. This law prohibits you from making any further disclosure of this information without specific written consent of the person to whom such information pertains. This authorization is not sufficient for this purpose.