AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: _____ **DOB:**_____/_____/_____ **ID#**_____

Release Information FROM *(Who holds the records?)*	**Release Information TO** *(Who receives the records?)*
Entity Name	Name
Address	Address
City/State/Zip	City/State/Zip
Phone	Phone
Fax/Email	Fax/Email

Purpose of Release: ☐ Continuation of Care ☐ Work Comp ☐ Disability Determination ☐ Personal
☐ Insurance Claim ☐ Legal ☐ Other: _____

Information to be Released:

☐ Crisis Plan ☐ Physician Notes ☐ RN Notes
☐ Progress Notes ☐ Psychiatric Evaluations ☐ Assessments
☐ School Records ☐ Medical Reports ☐ Treatment Plans
☐ Psychological Summary ☐ Medications ☐ Discharge Summary
☐ Guardianship Paperwork ☐ Written & Verbal Communications Pertinent to Treatment
☐ Other (Please be specific): _____

Date range of records for release: _____ to _____

This form implements the requirements for consumer authorization to use, disclose and exchange health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R part 2), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services.

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand if I authorize disclosure of my protected health information to someone who is not covered by confidentiality laws, for example, a family member, it is possible that my information may be re-disclosed by that person to someone else.

I, _____, authorize the use/disclosure/exchange of information in my medical record relating to acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV) _____ *(initials)* and/or genetic information _____ *(initials).*

****ADDITIONAL DOCUMENTATION REQUIRED FOR SUBSTANCE USE CONSENT. Refer to the "Consent for Disclosure of SUD Records" form.**

I understand that I may refuse to sign this authorization form. Refusal to sign will not be a condition to obtain treatment, payment for or coverage of services, or eligibility for benefits or enrollment.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to the information that has already been released in response to this authorization.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction and a copy of this form is as valid as the original to allow release of my records.

If not revoked earlier, this authorization expires on: _____ (date) not to exceed one year of signature date.

Signature: _____ **Date:** _____

Printed Name: _____ **Phone #:** _____

Relationship to consumer: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other: _____

Witness Signature:_____ Date: _____

Administrative Use Only
****Note: This authorization to use and disclose information was revoked on _____ (Date) ****