

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize _____ (the "Covered Entity") to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I also understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form. Finally, I understand that if the recipient I authorize to receive the information is not a covered entity, the released information may no longer be protected by federal and state privacy regulations.

Name of Patient/Individual (Please Print)	DOB	Phone	E-Mail (Optional)
Street	City	State	Zip

I AUTHORIZE THE COVERED ENTITY TO DISCLOSE THE PATIENT/INDIVIDUAL'S PHI TO:

Person/Organization	Phone	Fax
Street	City	State Zip

REASON FOR DISCLOSURE:

<input type="checkbox"/> Treatment/Continuing Medical Care	<input type="checkbox"/> Legal Purposes	<input type="checkbox"/> Employment
<input type="checkbox"/> Personal Use	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> At the Request of the Patient/Individual
<input type="checkbox"/> Billing or Claims / Insurance	<input type="checkbox"/> School	<input type="checkbox"/> Other:

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first box – "All Health Information" and initial other specific types of information to be released:

<input type="checkbox"/> Specific Dates of Services: _____	<input type="checkbox"/> All Health Information <input type="checkbox"/> Patient History <input type="checkbox"/> Progress Notes <input type="checkbox"/> Past/Present Medications <input type="checkbox"/> Diagnostic Test Reports <input type="checkbox"/> Billing Information <input type="checkbox"/> Other: _____
OR	
<input type="checkbox"/> All Date of Services	

Your initials are required to release the following information:
_____ Mental Health Records (excluding psychotherapy notes ¹)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information
_____ HIV / AIDS Test Results or Treatment

SUBSTANCE USE DISORDER RECORDS. I understand that my substance use disorder patient records received by Covered Entity are protected under federal regulations 42 C.F.R. Part 2 Confidentiality of Substance Use Disorder Patient Records ("Part 2 records") and cannot be disclosed without my written consent. I consent to disclosure of my Part 2 records for future uses and disclosures for treatment, payment and health care operations. I understand that my Part 2 records may be redisclosed in accordance with the permissions contained in HIPAA, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me. I understand that Part 2 records used or disclosed pursuant to this consent may be redisclosed and no longer protected by Part 2: _____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of: the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date (optional): _____

RIGHT TO REVOKE. I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. My revocation is effective when Covered Entity received my written request.

NOTICE OF PRIVACY PRACTICES. By signing this authorization, I acknowledge that I have been provided a copy of, have read, and understand the Covered Entity's Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosures, under HIPAA.

Signature of Patient, Parent, or Legal Guardian	Printed Name of Patient, Parent, or Legal Guardian	Date
OR	Legal Authority (Attach Supporting Documents)	
Relationship to Patient		

*In addition to Parent / Legal Guardian, a minor's signature is required for the release of certain types of information, including the release of information related to certain types of reproductive care, sexually transmitted diseases, drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor Patient (If Applicable)

¹ An authorization for use or disclosure of psychotherapy notes and/or substance abuse counseling notes may not be combined with authorization for release of other PHI. A separate authorization is required.