

Authorization to Release Protected Health and/or Substance Use Disorder Records

Authorization to Release Protected Health Information Of:

Patient Name:	Date of Birth:	Phone Number:
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Address:

Authorization to Release Protected Health Information From:

Facility Name/ Provider:	Phone Number:	Address:
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Authorization to Release Protected Health Information To:

Agency/Individual (include contact person):	Relationship to Patient:	Phone Number:
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Address:

Purpose of Disclosure:

Dates of Treatment/Service Requested (mm/dd/yy --mm/dd/yy):

Delivery Information:

In Person Mail Oral/two- communication Secure Email Address:
 Fax Number: Other electronic format(check with provider for available electronic options)::

Release the Following Information (check all that apply):

Patient Health Information:

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Emergency Room Records	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Consultation
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Report	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Outpatient Clinic Records
<input type="checkbox"/> Medication List	<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> HIV/AIDS or other communicable disease	

Other _____

Mental/Behavioral Health Information:

<input type="checkbox"/> Evaluation/Assessment Summary	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Therapy Records	<input type="checkbox"/> Discharge
<input type="checkbox"/> Medication List				
<input type="checkbox"/> Consultation				
<input type="checkbox"/> Other _____				

Substance Use Information:

<input type="checkbox"/> Evaluation/Assessment Summary	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Consultation	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Therapy Records	<input type="checkbox"/> Discharge
<input type="checkbox"/> Drug Test Results					
<input type="checkbox"/> Medication List					
<input type="checkbox"/> Other _____					

Financial:

Health Insurance Claim Form Billing Form Itemized Billing Other _____

Authorization Will Remain in Effect for:

1 year from date signed one time disclosure other(date/event/condition):

I understand that:

- I understand that the information to be released may include reference to sensitive information related to drug or alcohol abuse treatment which may be federally protected Under 42 CFR Part 2, genetic testing, HIV/AIDS or other communicable disease and/or mental/behavioral health. By checking the boxes related to this information this disclosure will reveal my presence as a patient at this treatment facility and/or that I am receiving this type of treatment.
- Once this facility/provider discloses my health information by my request, it cannot guarantee the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by federal and state law governing the use and disclosure of my health information.
- The facility/provider will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
- I may inspect, request, or copy any information used or disclosed under this authorization. If I have questions about disclosures of my health information, I can contact the facility/provider and speak to their medical records department.
- This authorization is subject to revocation at any time except to the extent that the facility/provider or other lawful holder of the protected health information has already acted in reliance of this authorization. The revocation must be provided in writing to the "facility."

Signature of Patient or Representative	Date:
Printed Name of Representative:	Relationship to Patient: