Authorization to Disclose Protected Health Information



**Date/Fecha:**

**This Document is a/Este documento es:**

**□ Release-This Agency to Other □ Request-Other to this Agency □ Release AND Request**

**Lanzamiento de esta agencia a otra Solicitud de otra agencia a esta Lanza y Solicita**

**Regional Health Systems**

**To/From/De/Para:**

**Name of Person or Organization/Nombre de la persona o de la organizacion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address/Direccion:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client name/Nombre del cliente:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB/Fecha de nacimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address/Direccion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/Ciudad:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State/Estado: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Zip/Cierre relampago:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone/Numero de telefono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Release information/Lanzamiento de:**

**□ All Protected Health Information/Toda la informacion protegida de la salud**

**□ Substance Abuse Information/Informacion del abuso de la sustancia**

**□ HIV-related Information/Infomacion VIH-Relacionada**

**□ Intake Narrative/Historia narrative del producto**

**□ History + Physical/Comprobacion & Physco**

**□ Psychiatric Evaluation/Laboratorio de la evaluacion**

**□ Psychological Evaluation/Evaluacion psiquiatrica**

**□ Assessments/Gravamenes**

**□ Progress notes/Notas de progreso**

**□ Transfer/Discharge Summaries/Transferencia/Resumenes de la descarga**

**□ Treatment Plan Reviews/Plan del tratamiento/revisiones**

**□ Notification of Emergency/Notificacion de la emergencia**

**□ Service Dates/Servicio fecha**

**□ Diagnosis/Diognosticos**

**□ Verbal Communication Only-Communicacion verbal/Comunicacion linguistica**

**□ Other/Otro**

**□ Primary Care Information/Informacion del cuidado primario**

**Only release information with this date of service/Solo lanza informaccion desde esta fecha: \_\_\_\_\_\_\_\_\_**

**Through this date of service/Hasta esta fecha: \_\_\_\_\_\_\_\_\_\_**

**Method of Disclosure/Metodo de lanzamiento de revelacion:** □Paper/paper □OralHablado □Electronic/Electronico,

**Disclosure Purpose/Razon de revelacion:**

**□ Continuation of Treatment/Continuacion de tratamiento**

**□ Collaboration with School/Colaboracion con la escuela**

**□ Legal Proceedings/Procedimientos legales**

**□ Insurance Claims/Rec;a,em de segiransa**

**□ Response to Referral Source/Repuesta de referencia**

**□ In case of Emergency/En causo de emergencia**

**□ Other (Specify)/Otra razon (specifica)**

Other purpose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that I may revoke this authorization by notifying the Regional Health Systems in writing of my desire to revoke it.** **If not previously revoked, this authorization will expire 180 days from the date of signature unless otherwise specified.**

**(Specify a date, event, or condition upon which this consent expires, not longer than 180 days)**

**Entiendo que puedo revocar esta autorizacion notificando a Regional por escrito mi deseo de revocarla.**

**Si no anteriormente reocada, esta autorizacion se expira en 180 dias de la fecha firmada sino aun otra razon.**

**(Specifica fecha, evento o condicion en qual esta autorizacion se espira, si no mas de 180 dias).**

**Expiration Date or Event/ Fecha de Espiracion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This agency disclaims responsibility or liability for any use including re‑disclosure by the recipient or if disclosure to the**

**recipient pursuant to this authorization, or any use or re‑disclosure by the recipient, causes the information to lose**

**protection from further disclosure by federal or state law, including 45 CFR Part 164 HIPAA regulations.**

**42 CFR 2.32: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR**

**part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is**

**expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.**

**A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal**

**rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

**Esta agencia desclama resoncibilidad o lastre por uso de esta informacion en parte o en total, revelacion por el receptor o revelacion de parte de el receptodor de acuerdo de esta autorizacion, uso de alguna parte de parte del receptor, causa la informacion a perded proctecion de mas revelacion por Federal o Estado de la ley, inclussivo de las reglas de 45 CFR parte 164 HIPPAA**

**42 CFR 2:32: Esta information e cido revelada a usted del registro protejido por las reglas confedencias Federal (42CFR parte 2) Las reglas Federales prohive que usted cometa revelacion mas alla de esta informacion sino esta recevelacion es espresivamente permetida por permiso escrito de la persona con quien se pretencese o de lo contrario permetida por 42 CFR parte 2.**

**La autoracicion general para la revelacion de informacion medica o otra informacion NO es suficiente para esta razon.**

**Las reglas Federal restring uso del a informacion para investigar para intenciones criminal o procesar al paciente del abuso de alcohol o droga.**

**A photocopy or electronically produced or reproduced copy is as valid as the original.**

**Copia de retrato o electronico producido o reproducido es tan valido como el original.**

**Release Status/La posicion social**

**□ Active /Activo**

**□ Revoked by Client/Cliente renuncio (derogo)**

**Reason for evocation/Razon por derogo renunci :**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client/Parent Guardian SignatureFirma de Cliente/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date/fecha:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature/Testigo**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date/Fecha**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_