Authorization to Disclose Protected Health Information



**Date:**

**This Document is a:**

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

**Regional Health Systems**

**To/From (Enter Name and Adress):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Client name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Release information:**

**□ All Protected Health Information**

**□ Substance Use Information**

**□ HIV-related Information**

**□ Intake Narrative**

**□ History + Physical**

**□ Psychiatric Evaluation**

**□ Psychological Evaluation**

**□ Assessments**

**□ Progress notes**

**□ Transfer/Discharge Summaries**

**□ Treatment Plan Reviews**

**□ Notification of Emergency**

**□ Service Dates**

**□ Diagnosis**

**□ Verbal Communication Only-**

**□ Other**

**□ Primary Care Information**

**Only release information with this date of service: \_\_\_\_\_\_\_\_\_Through this date of service: \_\_\_\_\_\_\_\_\_\_**

**Method of Disclosure:** □Paper □Oral □Electronic,

**Disclosure Purpose:**

**□ Continuation of Treatment**

**□ Collaboration with School**

**□ Legal Proceedings**

**□ Insurance Claims**

**□ Response to Referral Source**

**□ In case of Emergency**

**□ Other (Specify)**

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

**I understand that I may revoke this authorization by notifying the Regional Health Systems in writing of my desire to revoke it. It is also understood that this authorization,** **if not previously revoked, 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.)**

**Expiration Date or Event:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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.**

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

**Release Status**

**□ Active**

**□ Revoked by Client**

**Reason for revocation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client/Parent Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_