Client Name: **Client ID:**

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):____

____

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

Client Name: **Client ID:**

□ **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**:__________________