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Protected Health Information (PHI) Release Authorization

Name (First, MI, Last) \_\_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_
Mailing Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_
Phone Number (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

I hereby authorize disclosure of my Protected Health information as follows:

Specify REASON for Release: \_\_\_ Transfer of Care \_\_\_ Ongoing Care/Specialist \_\_\_ Legal \_\_\_ Personal
\_\_\_ Billing/Insurance \_\_\_ Other: \_\_\_\_\_

Specify WHO: Obtain FROM: \_\_\_ Our Organization Release TO: \_\_\_ Our Organization
Facility & Person: \_\_\_\_\_ Facility & Person: \_\_\_\_\_
Address: \_\_\_\_\_ Address: \_\_\_\_\_
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Specify DATES & RECORDS to be released: Mark or describe

Specify Dates of Service: from \_\_\_\_\_ to \_\_\_\_\_

Specify Items (may include information related to Mental Health, Drug/Alcohol, Genetic Testing, HIV/AIDS, & External Records)

- Office Visit Notes Lab Results Imaging Reports Procedure/Surgery Notes
Consultations Test Results Medications/Pharmacy Billing Reports
HIV/AIDS Alcohol/Drug/Substance Abuse Genetic Testing Mental Health
Entire medical record (includes Mental Health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, & External Records)
Other: \_\_\_\_\_

I, the Patient, OR Authorized Person of Patient, UNDERSTAND:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
I may choose to refuse to sign this form.
I have the right to inspect or copy the information I am consenting to release within the organization's established policies.
My right to healthcare treatment is not conditioned on this authorization.
I understand that disclosure of this information carries with it the potential for re-disclosure and the information may not be protected by federal/state confidentiality rules.
There may be a charge for the requested records.
This release will expire 12 months after date of signature unless date is specified: \_\_\_\_\_
Unless otherwise specified, release may be in any reasonable manner including: verbal, paper, unencrypted fax/electronic.

PATIENT/Authorized Person SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Person NAME (print): \_\_\_\_\_ Relationship: \_\_\_\_\_

For Substance Abuse Disorder treatment information (covered by 42 CFR Part 2): Notice to recipient of protected information: 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.