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Protected Health Information (PHI) Release Authorization

Name (First, MI, Last) \_\_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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

Release FROM: SFFH or Specify:
Facility & Person: \_\_\_\_\_
Address: \_\_\_\_\_
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Release TO: SFFH or Specify:
Facility & Person: \_\_\_\_\_
Address: \_\_\_\_\_
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Specify DATES to be released: Mark or describe Unlimited \_\_\_\_\_ (First visit through expiration of this release)
Limited From \_\_\_\_\_ to \_\_\_\_\_ Limited From \_\_\_\_\_ to: Ongoing to expiration of this release

Specify for VERBAL topics to be released/discussed: Mark or describe

- Medical information, including, but not limited to: my symptoms, diagnosis, medications and treatment plan.
Behavioral health information, including, but not limited to: my symptoms, diagnosis, medications and treatment plan
Labs, X-Ray, Drug/Alcohol Screening and other test results
Billing and Payment Information (including, but not limited to: balances, insurance & bills)
Appointments: including, but not limited to: schedule, verify, cancel, etc
Other (be specific) \_\_\_\_\_

Specify RECORDS to be released: Mark or describe

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

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

- This release will expire 12 months after date of signature unless date is specified: \_\_\_\_\_
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.
Unless otherwise specified, release may be in any reasonable manner including: paper, unencrypted fax/electronic.

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

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

For Substance Abuse Disorder Program 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.