Authorization for Release of Personal Health Information and Medical Records

This release of information will allow another person to access your medical information. (This includes health information, which is any information that relates to your past. present, or future physical or mental health or medical condition. I authorize the disclosure of my personal health information as described below. I understand that this authorization is voluntary.

I hereby give permission to: _____

☐ exchange information with ☐ to release information to

Name: _____
Address: _____
Telephone: _____

Personal Health Information to be disclosed: **Circle all that apply**

presence in treatment/dates of treatment discharge status diagnosis(es)

description of progress in treatment emergency information prognosis

history and physical progress notes treatment plan and updates

biopsychosocial assessment prescriber assessment medications

physician orders drug screens laboratory reports

discharge summary continuing care plan discharge instructions

Other: _____

ALL OF THE ABOVE

Purpose of this release of information Coordinate Care Other : [BLANK]

Disclosure Format: Paper/Mail/Fax Email Other Electronic Format
Verbal All of the Above

I understand that information regarding my alcohol and/or drug treatment is protected by federal law under the Drug Abuse Prevention Treatment and Rehabilitations Act and the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and their implementing regulations. See generally 42 C.F.R Part 2; 45 C.F.R Parts 160, 164. I understand that my health information as specific on this form, will be disclosed pursuant to this authorization that the recipient of the information may redisclose the information and it may no longer be protected by federal law under HIPAA. Federal law governing confidentiality of alcohol and drug abuse patient information noted above however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure.

Right to revoke: I may revoke this authorization at any time except to the extent that action has been taken. If I do not revoke it. this authorization will expire upon my discharge from the agency. To revoke this authorization, I will contact the Program Director/Coordinator and make a written request to cancel consent.

Client Signature: _____

Staff signature: _____