Patient Authorization Form For Release of Protected Health Information

I. I hereby voluntarily authorize the disclosure of information from my record, as identified below:

Patient name:_____ Age:_____ Date of Birth: _____
Address:_____ Telephone #: _____
City/State/Zip:_____ ☐ Adult ☐ Emancipated Minor ☐ Unemancipated Minor

II. INFORMATION IS TO BE **RELEASED BY**:	AND IS TO BE **PROVIDED TO**:
Name/Entity: Address: City/State, Zip:	Name/Entity: Address: City/State, Zip:

III. The purpose or need for this disclosure is:

☐ Further medical care ☐ Attorney ☐School ☐ Research ☐ Insurance

☐Other (specify):_____

IV. Type of information to be released (check appropriate box(es)):

☐ Entire medical record (**sensitive** information will not be released unless additional boxes checked below)
☐ Behavioral Health record (including but not limited to counseling session times & frequency, diagnosis, treatment plan, symptoms, prognosis & progress to date. This does not include psychotherapy notes.)
☐ Only information related to (specify):_____
☐ Only the period of time from _____ to_____
☐ Lab Results (specify): _____
☐ X-Ray Reports (specify): _____
☐ Other (specify): _____

If you would like any of the following **sensitive** information disclosed, check the applicable box(es):
☐ Sexually transmitted diseases ☐ HIV/AIDS related treatment
☐ All substance use disorder treatment information ☐ Other (specify):_____
☐ Psychotherapy Notes Only (this request cannot be combined with other requests for information)

V. Authorized format(s) for release: ☐ Written ☐ Verbal ☐ Fax: _____ ☐ Secure Email:_____

VI. I understand my records are protected and cannot be disclosed without my written consent unless otherwise provided for under applicable law. I may revoke this consent at any time except to the extent an action has been taken in reliance on it before my revocation was received. If this consent has not been revoked, it will expire one year from date signed, unless I am specifying a different expiration date or event here (specify):_____. I understand that no one may condition treatment or eligibility for care on my providing consent, except if such care is research related or provided solely for the purpose of creating protected health information for disclosure to a third party, or as otherwise allowed or required by law. This statement shall be included with each disclosure made under this consent that includes substance use treatment records: "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 these purposes (see 42 CFR 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."

VII: Signature Required for Authorization to Be Valid:

Signature of Patient or Personal Representative (state relationship to patient):	Date:

Office Use Only
Pgs._____ Date:_____ Staff Initials_____
Method: ( ) In Person ( ) ID verified ( ) Mail ( )Fax

Phone Request:
3 forms of identification needed ***(SSN or Gov Issued ID required)***
Employee Signature: _____
Printed Name: _____ Date: _____