AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability Act of 1996 (HIPAA)

Completion of this document authorizes the disclosure and/or use of health info about you. Failure to provide ALL info requested may invalidate this authorization.

Name: ____ DOB: ________________

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize ____

To release info to: ____

(Persons/Organizations authorized to receive the information Address, street, city, state, zip)

The following info is to be released: (check all that apply)

A.

- o Assessment/History and Physical – Dates of Service ___________________________
- o Discharge Summary – Dates of Service ____________________________________
- o Lab Tests – Dates of Service ____
- o Radiology Reports – Dates of Service ______________________________________
- o Entire Record – Dates of Service ____
- o Other (please specify needed info and dates of service if known) ____

B. I specifically authorize the release of the following info (check as appropriate):

- o Mental health treatment info (a separate authorization is required to authorize the disclosure of use of psycho therapy notes)
- o HIV results
- o Alcohol/Drug treatment information
- o Genetic Information

______ **Intitial**. I understand that the info in my medical record may include info relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include info about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

______ **Initial**. I understand my treatment cannot be conditioned on the signing of this authorization.

______ **Initial**. This authorization remains valid for 2 years from signature date

______ **Initial**. Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested.

Purpose (Check one)

- o Insurance or other third party reimbursement
- o Continuity of medical care
- o Pending legal action
- o At the request of patient for own personal purposes
- o Other: ____

Restrictions

According to federal and state regulations, of the information requested relates to any AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third party as required by law.

I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and it's employees have responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release __________________________ and employees of any liability that may arise as a result of any subsequent disclosure of my health info by the recipient.

My Rights

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
I may revoke this authorization at anytime, but I must do so in writing and submit it to the following address:

____
____
____

My revocation will take effect upon receipt, except to the extent that other have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

Signature ____
Date: ___________________________
Relationship to patient: ____