AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Complete all sections, date, and sign

I. AUTHORIZATION

I, _____ , hereby voluntarily authorize the disclosure of information from my health record.
(Name of Resident/Patient)

II. THE INFORMATION IS TO BE DISCLOSED BY:	**III. AND IS TO BE PROVIDED TO:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE
	METHOD OF DELIVERY (mail, email-must be secure, fax, etc.)

IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment or Other Healthcare Operations ☐ Attorney ☐ School ☐ Other *(Specify)* _____

☐ Personal Use ☐ Disability ☐ Health Information Exchange _____

V. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS-related Treatment ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Sexually Transmitted Diseases ☐ Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

VI. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. _____
(Specify new date (mm/dd/yyyy) or expiration event)

I understand that this organization will not condition treatment or eligibility for care on my providing this authorization.

SIGNATURE OF RESIDENT/PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to resident/patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of resident/patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual under false pretenses shall be guilty of a misdemeanor.

PATIENT IDENTIFICATION

	NAME *(Last, First, MI)*	
	ADDRESS	
	CITY/STATE	
	DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

Instructions for Completing AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of resident/patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Section III, provide the name of the person, facility, and address that will receive the information.
4. Section IV, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc.
5. Section V, check the appropriate box as applicable.
   a. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.
   b. **Only the period of events from** – specify date range, e.g., Jan. 1, 2025, to Feb. 1, 2025.
   c. **Other (specify)** – e.g., Billing, Employee Health.
   d. **Entire Record** – complete record including, **if authorized** (see e below), the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
   e. IN **ORDER** TO RELEASE SENSITIVE INFORMATION **regarding Alcohol/Drug Abuse Treatment/Referral, HIV/ AIDS-Related Treatment, Sexually Transmitted Diseases, Mental Health (Other Than Psychotherapy Notes),** the appropriate box or boxes *must* be checked by the resident/patient.
   f. **PSYCHOTHERAPY NOTES ONLY – In order to authorize the use or disclosure of Psychotherapy Notes** (which are separate from progress notes and contain the therapist's impressions and the content of psychotherapy conversations), **ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. Authorizations for the use or disclosure of other health record information may not be made in conjunction with authorizations pertaining to psychotherapy notes.**

      NOTE: If this box is checked with other boxes, another authorization will be required to authorize the use or disclosure of psychotherapy notes only.
6. Section VI, if a different expiration date or event is desired, please specify.
   a. If authorizing the release of records for court-ordered substance use disorder treatment, the expiration date/event must be no later than the final disposition of the criminal proceeding.
7. Section VI, Please sign (or mark) and date.
8. A copy of this completed form will be offered to you.

ATTACHMENT A

(To be given to Party Receiving Records)

Prohibition of Disclosure

This information has been disclosed to you from records whose confidentiality is protected under Federal law. Federal Regulations (42 CFR Part 2) prohibit you (the recipient) from making any further disclosure of this information except with the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical records or other information is NOT sufficient for this purpose.

ATTACHMENT B

(This Notice Must be Given to Residents/Patients Whose Record Are Released)

CONFIDENTIALITY OF **ALCOHOL** AND **DRUG** ABUSE RESIDENT/PATIENT RECORDS

The confidentiality of **alcohol** and **drug** abuse resident/patient records maintained by the facility is protected by Federal law and regulations.

Generally, this facility may not say to a person outside the program that a resident/patient attends the program, or disclose any information identifying a resident/patient as an **alcohol** or **drug** abuser Unless:

(1) The resident/patient consents in writing;

(2) The disclosure is allowed by a court order: or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a resident/patient either at the facility or against any person who works for the facility or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected abuse or neglect from being reported under State law to appropriate State or local authorities.