AUTHORIZATION FOR RELEASE OF INFORMATION
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____
(Last) (First) (MI)

DOB:_____ SS#:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

☐ Discharge Summary
☐ Mental Health Assessment
☐ Physician Orders
☐ General Progress in Treatment
☐ Continued Stay Reviews
☐ Continued Care Plan
☐ History & Physical
☐ Treatment Plan
☐ Dates in program
☐ Discharge Criteria
☐ Correspondence (Letters)
☐ Admission Notes
☐ Progress Notes
☐ Medication Records
☐ Interdisciplinary Notes

Date Release Revoked:

☐ Other (Please be specific) _____

Purpose of need for disclosure is _____

Permission is hereby given to EXCHANGE information with:

_____
_____
_____

AND

_____
_____
_____

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as otherwise permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is **NOT** sufficient for this purpose.

I, the undersigned, have read the above and authorize staff of the disclosing facility named to disclose such information as herein contained. I understand that I may revoke or cancel this authorization at any time. Withdrawal of the authorization does not affect any information disclosed before providing a written notice of such a withdrawal of authorization. **This authorization will remain in effect for 180 days in order to carry out the purpose for which my permission was given.** I understand that the program releasing these records is free from all legal liabilities that may arise from this act. I understand that I have the right to limit the information that is to be disclosed and who can see this information. A photocopy of this authorization is as valid as the original.

_____ _____
Patient Signature Date Facility Witness Signature Date

(☐) I Cancel My Permission To Disclose The Information Described On This Form.

_____ _____
Patient Signature Date Facility Witness Signature Date

This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part2) and the Health Insurance and Portability and Accountability Act of 1996 (HIPAA 45 C.F.R. Parts 160 & 164) Federal laws prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 of HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules and laws restrict any use of the information to criminally investigate of prosecute any alcohol or drug abuse patient.

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