



Patient Name _____	Maiden / Other Name _____
Patient Address _____ Street	City _____ State _____ Zip _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ hereby authorize _____ its Director or Designee, or Health Information Management/Medical Records Department, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any; behavioral medicine services record, if any, including communications made by me to a social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5131, if any, which includes venereal disease, tuberculosis, HIV, AIDS, and ARC, to individuals or organizations listed below, only under the conditions listed below:

1. Name of person(s) or organization(s), to whom information is to be released to:

Name _____
 Street Address _____
 City _____ State _____ Zip Code _____

I understand that my protected health information disclosed under this Authorization may be subject to redisclosure by the individual or organization named above and its privacy will no longer be protected by the law.

2. Specific type of information to be disclosed:

The authorized person *must initial next to the type of information to be disclosed.*

_____ ER Report	Date of Service _____
_____ Initial Assessment	Date of Service _____
_____ Inpatient Summaries	Date of Service _____
_____ Medication Evaluation	Date of Service _____
_____ X-ray Reports	Date of Service _____
_____ Laboratory Tests	Date of Service _____
_____ Operative Reports	Date of Service _____
_____ Psychiatric Evaluation	Date of Service _____
_____ Psychotherapy Notes	Date of Service _____
_____ Discharge Summary	Date of Service _____
_____ Information regarding _____	
_____ Other – Describe records required and give approximate date(s) of service:	

3. The purpose and need for such disclosure:

- | | | |
|--|---|---|
| <input type="checkbox"/> Employer Request | <input type="checkbox"/> Disability Certification | <input type="checkbox"/> Continuation of Care |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Insurance Claim | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Social Service | <input type="checkbox"/> Insurance Application | <input type="checkbox"/> School Requirement |
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Attorney Inquiry | <input type="checkbox"/> Personal Use |
| | | <input type="checkbox"/> Research |

Other (specify) _____

4. This authorization can be revoked, in writing, at any time except to the extent that information has already been released or disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved. We will not condition treatment or payment based upon this Authorization or Revocation of Authorization unless otherwise allowed by law.

5. This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days after the date below, whichever is later.

Signature of Patient _____ Date _____ Time _____

Birth Date of Patient _____ Social Security Number of Patient _____

Consent of legal guardian, patient advocate or personal representative if patient is incapable or is a minor.

Signature of guardian, patient advocate or personal representative _____ Date _____ Time _____

Relationship _____

Address _____ Witness _____

Phone Number _____