AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: ____ Patient Social Security Number: ___________________________

Patient Address: _______________________________________ Patient Date of Birth: ______________________

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9, I specifically authorize the release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact HHS and/or the state agencies responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCLOSE MY HEALTH INFORMATION OR MEDICAL CARE TO ANYONE OTHER THAN THE RECIPIENT SPECIFIED IN ITEM 8.

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7. Name/address of health provider or entity that this release is directed to: ____

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8. Name/address of person(s) or category of person to whom this information can disclosed: ______________________________

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9. Specific information to be released (check boxes and complete, as appropriate):

   ☐ Medical Record (including, if applicable: patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers)

   ☐ Medical Record from (insert date) _________________ to (insert date) ___________________

   ☐ Other: ____

   ☐ Include the following: (*Indicate by Initialing*)

   __________ Alcohol/Drug Information
   __________ Mental Health Information
   __________ HIV-related Information

10. Reason for release of information: ____

11. Date or event on which this authorization will expire: ____

12. If not the patient, identify the person signing this form: ____

13. Authority of the person identified above to sign this form: ____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

____ ___________________________________

Signature of Patient/Authorized Representative Date:

***Note:** The Company reserves the right to charge for the production of records, in accordance with HIPAA.