ATTACHMENT B

AUTHORIZATION TO RELEASE/REQUEST PROTECTED HEALTH INFORMATION

410-837-5533 | Fax: 410-244-8598

CLIENT INFORMATION

Client Name (First and Last): _____

Date of Birth: _____ Client Telephone Number: _____

I, Authorize: _____ **To Release to**: _____

_____ _____

_____ _____

This information is to be limited to the following: Date(s) of service:

_____

_____

❒ History and Physical

❒ Medical Progress Note

❒ Nursing Notes

❒ Medication Sheet

❒ Labs/X-Rays/Consultations

❒ Mental Health Records including psychotherapy notes

❒ Addictions Records

❒ Social Service Records

❒ Other (please specify) _____

❒ The information designated above is intended to include information received from a third party provided the third party has not prohibited re-disclosure.

Purpose of Request:
❒ At the request of the individual
❒ Legal
❒ Sharing with other Health Care Providers as needed
❒ Other (please specify below)

_____

PART B – SPECIAL CATEGORIES OF HEALTH INFORMATION : (circle appropriate response and initial if applicable)

I DO / DO NOT authorize to release information pertaining to psychiatric, drug/ or alcohol abuse, sexually transmitted diseases. **Initials:_____**

I DO / DO NOT authorize to release information pertaining to HIV/AIDS related testing, diagnosis and/or treatment. **Initials:_____**

I DO / DO NOT authorize to release information pertaining to Mental Health Records including psychotherapy notes **Initials:_____**

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. **Unless I revoke my consent earlier, this consent will expire automatically one (1) year from the date as written in the signature line below.**

I understand the following:

- This request will be processed within 30 days.
- I need not sign this form to ensure healthcare treatment or payment.
- I have the right to revoke this authorization at any time.
- If I revoke this authorization, I must do so in writing to the attention of the Medical Record Department at HCH.
- My right to revoke does not apply to information that has already been released based on this authorization.
- I understand that if My Health Records does not contain any information related to mental health or substance use treatment, that, once disclosed, it is possible that My Health Information may be further disclosed by the recipient and no longer subject to protections under the HIPAA.
- This authorization will expire in one (1) year unless revoked or another date otherwise specified.

_____ _____

Signature (Client) Date

_____ _____

Parent or Guardian Signature
(Children under 18) Date

_____ _____

Print Name Relationship to Client