AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of Patient: _____ Date of Birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____
to release to: _____
(Persons/Organizations authorized to receive the information) (Address, street, city, state, zip code)

Patient's
Initials
_____ Patient requests records to be faxed to another facility or physician's office. Patient is aware of confidentiality risks involved and releases DCBHS from responsibility for this fax.
Fax number _____

The following information is to be released:

a. Assessment/History and Physical – Date(s) of Service:
   - ☐ Discharge Summary – Date(s) of Service:
   - ☐ Lab Tests – Date(s) of Service:
   - ☐ Radiology Reports – Date(s) of Service:
   - ☐ Entire Record – Date(s) of Service:
   - ☐ Other (please specify needed information and date[s] of service if known):

   _____

b. I specifically authorize the release of the following information (check as appropriate):
   - ☐ Mental health treatment information1 (A separate authorization is required to authorize the disclosure or use of psychotherapy notes.)
   - ☐ HIV test results
   - ☐ Alcohol/drug treatment information

Patient's
Initials
_____ I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

PURPOSE:

The purpose of the release of this information is:

- ☐ Insurance or other third-party reimbursement
- ☐ Continuity of medical care

- ☐ Pending legal action
- ☐ At the request of the patient
- ☐ Other: (Specify)_____

Patient's

Initials

_____ We will provide copies of medical records for small records (50 pages or less) at no cost to you. For any record greater than 50 pages, I understand that I or the person/facility receiving the records will be charged a medical record copying fee of $15.00. By initialing, I agree to pay these fees when I am billed for them by DCBHS.

RESTRICTIONS:

According to federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations; the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release DCBHS of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I have a right to receive a copy of this authorization. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

_____

_____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

SIGNATURE

Date: _____

Time: _____ am/pm

Signature: _____

(Circle one: patient / representative / spouse / financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

_____

Witness:

_____