CAN COMMUNITY HEALTH

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____

INFORMATION TO BE RELEASED FROM:

Individual/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

INFORMATION TO BE RELEASED TO:

Individual/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

PURPOSE OF DISCLOSURE: ☐ Continuity of Care ☐ Personal Use ☐ Other: _____

METHOD OF DISCLOSURE: ☐ Paper ☐ Fax ☐ Email: _____

I SPECIFICALLY AUTHORIZE RELEASE OF INFORMATION RELATING TO: (Check All that Apply)

Date(s) of Service (optional): _____

☐ Progress Notes ☐ Immunization Records ☐ Medication List

☐ Lab Results ☐ Radiology Results (Specify Test)

☐ Other: _____ ☐ Research/ Study Note(s)

☐ Abstract Medical Records (Outpatient Progress Notes, Labs, Radiology, Discharge Summary, Operative/ Procedure Note – for the duration of the last 1 (one) year of treatment)

I SPECIFICALLY AUTHORIZE THE RELEASE OF PSYCHOTHERAPY NOTES (Initial for Release)**

_____ **If selected, no other item on this form may be selected. A separate form must be completed. Psychotherapy notes use or disclosure is at the discretion of the Behavioral Health Clinician.

EXPIRATION DATE: This authorization will expire twelve (12) months from the date of signature, unless specified otherwise (insert date or event) _____.

Notice to Patient: I understand that this release may include sensitive information (mental and behavioral health, genetic testing, HIV/AIDS, Sexually Transmitted Infections, Family Planning, substance use disorder(s), and sexual assault). By signing this form, I grant consent to disclose my protected health information (PHI) to the individual(s) listed above. The Notice of Privacy Practices provides additional details on uses and disclosures of my PHI for treatment, payment, and health care operations and is available to me upon my request. I understand that the above information may be redisclosed by the recipient and may not be protected by federal privacy laws or regulations. Any information covered under the Privacy Rule (42 CFR part 2) will not be redisclosed. I understand that completing this authorization form is voluntary and that treatment will not be denied if signature is refused. I may request a list of PHI disclosure made on my behalf at any time.

I have a right to **revoke** my authorization, in writing to the Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this authorization. I am entitled to a copy of this **authorization form** after I have signed it.

Notice to Requester: The use or disclosure of PHI is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) and criminal penalties pursuant to 42 U.S.C. 1320d-6 may apply if knowingly and in violation of HIPAA.

_____ _____

Patient/Representative Signature Date

_____ _____

Printed Name Relationship to Patient

_____ _____

Witness (Optional) Date

This Section is for Office Use ONLY

Patient Name: _____

Pt DOB: _____

Pt Acct #: _____