# AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

Return Authorization to an office location /Fax: 419-214-3635/E-mail: medicalroi@harbor.org  Harbor Client ID #: _____

**Client Full Name** (First, Middle, Last): _____ **Date of Birth:** _____

**Dates of Services** (Release records only from the time period) *Choose One:*

☐ All Episodes/Admissions ☐ Most Recent Episode/Admission ☐ From: _____ (Date Required) To: _____ (Date Required)

**I hereby authorize Harbor to:** ☐ Obtain from ☐ Release to *(Check **both** for mutual exchange of information)*

Name/Facility: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax: _____ Email: _____

**Check the following information to be released for the dates of service indicated above. The disclosure may include paper, oral and electronic interchange unless indicated in the restrictions below.**

_____**Entire Medical Record** ***(which includes Substance Use Disorder (SUD) Information, but does NOT include HIV/AIDS/ARC information unless otherwise checked below*)***

| | | |
|---|---|---|
| ___ Diagnostic Assessment | ___ Attendance | ___ Diagnoses |
| ___ Psychiatric Diagnostic Evaluation (with medical) | ___ Schedule/Cancel Appointments | ___ Billing Statement |
| ___ Psychological Testing Evaluation Report | ___ Progress Notes | ___ Genetic Testing Information |
| ___ Medications | ___ Treatment Plan | ___ EAP Assessment |
| ___ Discharge Summary | ___ Urine Screens/Lab Results | ___ EAP Discharge |

___HIV/AIDS/ARC Information* ___ Other (must specify): _____

Restrictions (None unless indicated): _____

**Purpose(s) of Disclosure:** ___ Coordination of Treatment ___ Family/Friend Involvement ___ Personal ___ Legal ___ Aftercare/Follow-up ___ Treatment, Payment, Healthcare Operations (TPO) ___ Other (explain/identify): _____

If this authorization has not been revoked, it will expire on the date, event or condition below. Condition may be indefinite, until revoked. If no date or event is specified below, this authorization will expire in one year from the date signed.

**Expiration date**: _____ or Condition/event of expiration: _____ or ☐ **Condition: Until revoked** (12/31/9999)

Confidentiality Rules: Treatment records are protected under federal law, including 42 CFR Part 2 and HIPAA, and any applicable state laws.
42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE OF THESE RECORDS

- I understand that if the recipient of the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such recipient and will likely no longer be protected by federal privacy regulations. I understand that Harbor cannot control the recipient's use of the disclosed information.
- I understand and acknowledge that, unless I expressly request a limitation, if the recipient of this disclosure is a covered entity or business associate to whom the disclosure is being made for purposes of treatment, payment, or health care operations, the disclosed records (or information contained in the disclosed records) may be redisclosed by the recipient in accordance with the permissions contained in HIPAA regulations, except for uses and disclosures of SUD records for civil, criminal, administrative, and legislative proceedings against me.
- I understand that I can revoke this authorization at any time, except to the extent that action has been taken by Harbor in reliance on this authorization, and that the revocation must be signed and dated by me. Upon revocation, further release of information shall immediately cease.
- For more information about your privacy rights, please refer to our Notice of Privacy Practices.
- I understand that authorizing the use or disclosure of the above information is voluntary. I understand Harbor will not condition about treatment, payment, enrollment, or eligibility for benefits on the execution of this authorization.

_____ _____ _____
Signature of Client or Legally Authorized Representative | Print Name | Date

_____ _____
Relationship of Authorized Representative (if applicable) | PRINT Name of staff member facilitating this request.

_____ _____
Signature of Minor Client (For SUD Records Only) | Date

***I hereby REVOKE my consent for the release of the above information.***

Signature: _____ Date: _____ Relationship to Client: _____

bs: 12/13, 08/14, 10/14. as: 06/16, 9/16,6/17, 6/20, 4/22, 5/23, 3/26 (Attachment to Policy #202)