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 (Disclosure for a specific time period) *Choose One:*

____ Most Recent Episode/Admission ____ All Admissions/Episodes ____ Previous Six Months

____ Other (Specify) _____ 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: _____

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.

To authorize the disclosure of HIV/AIDS Testing, or Drug & Alcohol Information please check below.

___ Alcohol & Other Drug Diagnosis/Treatment Information ___ HIV/AIDS/ARC Information

___**Entire Medical Record** ***(Does not include HIV/AIDS Testing, or Drug & Alcohol Information unless checked above)***

___ Diagnostic Assessment	___ Psychiatric Diagnostic Evaluation	___ Genetic Testing Information
___ Psychological Testing Evaluation Report	___ Progress Notes	___ Billing Statement
___ Medications	___ Treatment Plan	___ EAP Assessment
___ Discharge Summary	___ Diagnoses	___ EAP Notes
___ Attendance	___ Urine Screens/Lab Results	___ EAP Discharge

___ Other (must specify): _____

Restrictions (None unless indicated): _____

Purpose(s) of Disclosure: ___ Coordination & Continuity of Treatment ___ Family Involvement ___ Personal ___ Legal
___ Insurance ___ Transfer from Practice ___ Aftercare/Follow-up
___ Other (explain/identify): _____

CONFIDENTIALITY RULES: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

If this authorization has not been revoked, it will expire on the date or completion of the event/condition below. If no date or event is specified below, this authorization will expire in one year from the date signed.
Expiration date (cannot be dated beyond 12 months): _____ Condition/event of expiration: _____

- 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 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.
- 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 of this authorization, further release of information shall immediately cease.
- For more information about your privacy rights, please refer to our HIPAA Notice of Privacy Practices.

_____ _____ _____
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 AOD 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 (Attachment to Policy #202)