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
___ Psychiatric Diagnostic Evaluation (with medical)
___ Psychological Testing Evaluation Report
___ Medications
___ Discharge Summary
___ Attendance
___ Schedule/Cancel Appointments
___ Progress Notes
___ Treatment Plan
___ Urine Screens/Lab Results
___ Diagnoses
___ Billing Statement
___ Genetic Testing Information
___ EAP Assessment
___ 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If this authorization has not been revoked, it will expire on the date, event or condition below.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

<u>I hereby REVOKE my consent for the release of the above information.</u>

Signature: _____ Date: _____ Relationship to Client: _____