

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Chart #: _____

Date of Birth: _____ Telephone Number #: _____

I hereby authorize: _____
Name of Organization Disclosing PHI

To release the following information to: _____
Name and Address of Person/Entity Authorized to Receive PHI

Information to be shared:

- Complete Record
 Radiology Report
 Lab Report
 EKG
 Immunizations
 Employee Health
 Sexually Transmitted Disease
 HIV/AIDS Treatment
 Alcohol/Drug Abuse Treatment (See SUD Disclosures Below)
 Optometry
 Dental
 Mental Health Treatment Records **(Allow 10 Business Days for Processing)**

Dates of Service Needed:

Dates: _____ to _____

The information may be disclosed for the following purpose(s) only:

- Continued Treatment
 Insurance
 Legal
 School
 Disability

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.
- I understand that I may revoke this authorization at any time by submitting a written request to the person or organization authorized to disclose my information. Revocation will not apply to information that has already been used or disclosed in reliance on this authorization. Unless I revoke this authorization earlier, it will remain in effect for **one year** from the date of signature.

Substance Use Disorder (SUD) Disclosures:

(Box must be checked to authorize disclosure of SUD treatment records.)

- I authorize the organization identified above to disclose my SUD treatment records to the person or entity identified above for the purpose(s) selected above.
- I understand that I am not required to authorize the disclosure of my SUD treatment *records* to receive care.
 - I understand that my SUD treatment records are protected under federal law, including 42 CFR Part 2 and HIPAA.
 - I understand this authorization is subject to the expiration and revocation terms stated above, including my right to revoke this authorization in writing at any time. I understand that unless I revoke this authorization earlier, it will remain in effect until the expiration date stated above.
 - I understand that information disclosed under this authorization may be redisclosed by the recipient, including HIPAA-covered entities and their business associates as permitted by applicable law. Once disclosed in accordance with this authorization, the information may no longer be protected by 42 CFR Part 2.
 - I understand SUD records may not be used or disclosed in civil, criminal, administrative, or legislative proceedings without my written consent or a court order, except as otherwise permitted by law.

Signature of Patient or Legal Representative

Date

Time

Description of Legal Representative's Authority

Expiration date (if longer than one year from date of signature)

<p>Authorization for Use or Disclosure of Health Information</p> <p>Rev. 3-2026</p>	<p>Patient Name, DOB, Chart #</p>
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