I hereby authorize the use of disclosure of my health information as described below to the following:

Name of Individual/Facility/Company to Receive PHI:

Address: _____

City/State/Zip: _____

Name of Individual/Facility to Disclose PHI:

Address: _____

City/State/Zip: _____

The specific information authorized for use or disclosure:

- ☐ Discharge or Treatment Summary
- ☐ Dates of Treatment
- ☐ Medical/Physical History
- ☐ Psychiatric Evaluation
- ☐ Social History
- ☐ Treatment Plans
- ☐ Medication History
- ☐ Progress Notes
- ☐ Other: _____

Dates of Treatment, if known: _____

The information will be obtained, used, or disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued treatment ☐ Legal ☐ Upon request of consumer or consumer's representative

☐ Other (specify) _____

- This authorization is voluntary and that I may refuse to sign the authorization.
- The organization authorized to receive my information may not be required by federal privacy regulations to protect my health information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements.
- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization, if already released. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.

The information you authorize for release may include records which may indicate the presence of a communicable, noncommunicable or venereal disease which may include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). Furthermore, your medical information may indicate that you are or have been treated for substance abuse issues.

Unless revoked or otherwise indicated, the authorization will expire on the following date _____
(not to exceed one year)

Consumer's Name: _____

Date of Birth: ____ / ____ / _____

Social Security #: _____ - _____ - _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Date

_____ _____
Signature of Witness Date

Revised 1/23/2009

Chart #: _____