# AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

**Return Authorization to an Office Location by:**
Fax to:: 513-559-2080 or 419-214-3635: **Harbor/CCHB Patient ID #:** ________________________

Site Name (Secor, North Prospect, Maxwell Ave, etc.): ____________________________________________________

Patient 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: ______________________ To: ____________________
(Date Required) (Date Required)

**I hereby authorize Harbor/CCHB to:** ☐ Obtain from ☐ Release to ☐ Share/discuss with
**Information to be shared can be:** ☐ Verbal only ☐ Written Records Only ☐ Verbal and Written Records

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.**

___**Entire Medical Record** ***(Does not include HIV/AIDS Testing, Genetic Testing Information or Drug & Alcohol Information. To authorize the disclosure of this information, you must also check below.)***

___ Alcohol & Other Drug Diagnosis/Treatment Information
___ Diagnostic Assessment
___ Psychological Testing Evaluation Report
___ Medications
___ Discharge Summary
___ Attendance
___ HIV/AIDS/ARC Information
___ Psychiatric Diagnostic Evaluation
___ Progress Notes
___ Treatment Plan
___ Diagnoses
___ Urine Screens/Lab Results
___ Genetic Testing Information
___ Peds Consultation/Notes
___ Billing Statement
___ EAP Assessment
___ EAP Notes
___ EAP Discharge
___ Other (must specify): ________________________________________________________________________________________________

**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. This Authorization to Disclose/Obtain Confidential Information will expire upon the date, condition, or event listed below:

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/CCHB 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/CCHB 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/CCHB 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 Patient 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