**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date Required) (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)