AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Maiden/Prior Names: _____ **Current Phone #:** _____

Current Address: _____ **Last 4 of SS#:** _____

_____ **Email Address:** _____

I would like my Protected Health Information to be:

☐ released to **OR** ☐ requested from
(Check 1)

☐ Self (address above)

☐ _____ _____ _____
Agency/Organization ***Telephone Number*** ***Street Address***

_____ _____ _____ _____ _____
Name/Attention to ***Fax Number*** ***City*** ***State*** ***Zip Code***

☐ **Via** (only when released to is selected above):

☐ Mail ☐ Fax ☐ Pick-Up ☐ Email: _____

I am requesting disclosure of my Protected Health Information for the following purpose(s):

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use

☐ Academic ☐ Legal Investigation ☐ Billing/Insurance

☐ Other: _____

Dates of Service Requested: _____

☐ I authorize the release of the following information **INCLUDING** all records that include any Substance Use Disorder and/or Substance Use Disorder Treatment records, and/or Mental Health Records

OR

☐ I authorize the release of the following information **EXCLUDING** all records that include any Substance Use Disorder and/or Substance Use Disorder Treatment records, and/or Mental Health Records

Only the information & records indicated below:

(check all that apply and/or specify if "Other" is checked)

☐ Transition of Care Packet ☐ Physician Orders ☐ Psychiatric Evaluation

☐ Lab/Diagnostic Reports ☐ History & Physical ☐ HIV Test Results & AIDS Treatment Records

☐ Discharge Summary ☐ Progress Notes ☐ Other: _____

This authorization will expire on: ____ / ____ / ____

(If not indicated, authorization will expire one year from signature date)

This form must be completed in full before signing:

_____ _____
Patient's Signature **Date/Time**
(required for ages 16 and older)

_____ _____ _____
Parent/Legal Guardian Signature **Date/Time** **Relationship to Patient**
(if applicable)

This authorization is intended to allow Rolling Hills Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

_____ _____
Revocation Signature **Date/Time**