**Authorization for Release of Patient Health Information**



**Arlington ⬩ Barberton ⬩ Broadway ⬩ Kent ⬩ Portage Path**

PO Box 7695

Akron, OH 44306

Tel: 888-975-9188 **⬩** Fax: 330-564-9984

Patient Name: «FirstName» «LastName» Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_«SSN»\_\_\_

Date of Birth: \_«DOB»\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_«MailingAddress1»\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_«PtCityStateZip»\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A) To be released FROM: B) To be released TO:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **C) For the purpose of**: | **D) Medical Records to Release**:  Date Range: \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_ | | **E) Substance Use Disorder (SUD) Records to Release**: |
| 🞏 Personal  🞏 Billing  🞏 Legal  🞏 Health Care  🞏 Marketing  🞏 Fundraising  🞏 Research | 🞏 Provider Office Notes  🞏 Immunizations  🞏 Operative/Procedure Reports  🞏 Behavioral Health | 🞏 Cardiology/EKG Reports  🞏 Lab/Path Reports  🞏 Radiology/X-Ray/MRI Reports  🞏 Other: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 Provider SUD treatment notes |

\_\_\_\_\_\_ I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, and substance use disorders and treatment.

\_\_\_\_\_\_ I understand and acknowledge that certain medical records related to substance use disorders are further protected by 42 CFR Part II and will not be released unless specifically authorized in Section E above.

I understand that I am not required to sign this authorization form and that the health care provider named above will not condition the provision of treatment or payment to me on the signing of this authorization, except that the health care provider named above may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. The health care provider named above may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

I understand that the information I authorize a person or entity to receive, except for substance use disorder records protected by 42 CFR Part II, may be re-disclosed and no longer protected by federal regulations.

I understand that I may revoke this authorization at any time by notifying the health care provider named above in writing, except where action has been taken in reliance on this authorization.

This authorization will expire one year from the above date unless I specify an expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Expiration date of authorization)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*\*Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

**Notice of Records Protected by 42 CFR Part II**

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.