HELEN ROSS McNABB CENTER (HRMC) **HRMC Case #:_____**

Authorization to obtain or release Protected Health Information
Patient's Name: _____DOB: _____ SSN last 4 digits_____
Phone #s:_____

☐ I authorize the Helen Ross McNabb Center Inc. _____
(Specify HRMC Service)

to ☐ **Release** ☐ **Receive** health and/or social service information on the individual named above to/from the **SECOND PARTY** as directed below: This release serves as a two-way or reciprocal release about my needs and the services I receive.

Second Party:
Name/Agency_____ Relationship to Patient:_____

Address: _____

City_____ State_____ Zip _____Phone:_____Fax:_____

Indicate the service time period of information that is to be disclosed: Time Period _____to_____

If the information to be used/disclosed contains any of the types of records or information italicized below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place my *initials* in the applicable space next to the type of information:

Type of Information: _____*HIV/AIDS* _____*Genetic* _____*Alcohol/Drug* diagnosis, treatment or referral information (Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information is to be disclosed.)

Please check either All or Limited to indicate how much Alcohol/ Drug information is to be disclosed:
☐ All A&D information or ☐ Limited A&D information (if Limited A&D, specify by checking the applicable choices of information below.)
Indicate the information that is to be disclosed for Social Services, Medical and/or Mental Health by checking the choices below:
☐ Diagnosis ☐ Progress Report(s) ☐ Assessments ☐ Prescribed Medications
☐ Treatment Plan ☐ Discharge Summary ☐ Evaluations ☐ Labs
☐ Other_____
_____
(Specific or meaningful fashion)

The purpose of the use or disclosure is: ☐ at the request of the individual; ☐ coordination of care; ☐ referral
☐ Other, (specify)_____
(Descriptive or specific reason)

Unless I specify differently, this authorization will expire on the following date, event, or condition specified; automatic expiration will occur in
☐ 60 days ☐90 days ☐180 days **event or condition_____**

If I fail to specify an expiration date or event, this authorization will expire in one hundred and eighty days from the date on which it was signed or at termination of treatment, whichever occurs first. ***Health information may relate to my past, present, or future physical or mental health or condition, the provision of my health care, or payment for my health care services.***

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit my revocation to the HRMC Privacy Officer or designee. I understand that the revocation will not apply to information that has been disclosed or used in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the use of this disclosure for the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that the Helen Ross McNabb Center will not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign the authorization.

I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law and could be re-disclosed by the receiving party. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, genetic testing information and drug/alcohol diagnosis, history, treatment, referral or rehabilitation for substance abuse (Federal confidentiality rules (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 the information to criminally investigate or prosecute any alcohol or drug abuse patient, therefore prohibiting the receiving party from re-disclosure without my consent.
Prohibition on re-disclosure. **The federal rules prohibits 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.**

Electronic copies of this Authorization or any amendments hereto shall be binding upon the parties, and electronic reproduction of signatures appearing herein or on any reproduction shall be deemed to be original signatures.

I have read, or have had read to me, the above statements and understand them as they apply to me. I understand that I may receive a copy of this signed authorization form.

X_____ _____
Signature of patient *legal guardian or *authorized representative **Date**
(Patients age 16 years of age or older who receive mental health treatment must sign. This signature requirement does not apply to patients who are receiving any form of substance abuse treatment)

_____ _____
Print Name and Relationship to patient **Signature of Witness**
Please provide legal documents to prove authority to sign on behalf of patient **11/9/16**