Bluegrass Community Health Center

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# Authorization for Release of Protected Health Information

| | | | |
|---|---|---|---|
| Patient's Name: | | | |
| Date of Birth: | | | |
| Street Address: | | | |
| City: | | State: | Zip Code: |
| Telephone: | | | |

☐ **Disclosure of Records To** ☐ **Obtain Information From** ☐ **View Records Only**

Individual/Agency/Hospital

Street Address City/State Zip Code

Telephone: Fax:

Information May Be: ☐ Faxed ☐ Mailed ☐ Picked up by: ☐ Other:

**Purpose** Records are to be released for the following purpose (s):
☐ Continuity of Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other:

**Covering the period of healthcare from:** Specific Date(s): to

**Information to Release** (check the records you would like):

☐ Complete Clinical Medical Record ☐ Immunization Record ☐ Newborn Record
☐ Last Visit ☐ Lab Reports ☐ Physical Exam & Vital Signs
☐ Tuberculosis Records ☐ Itemized billing records ☐ Other (specify):
☐ Psychotherapy Notes (if checking this box, no other boxes may be checked. A separate Authorization to Release Protected Health Information must be completed to obtain additional records.)

I understand that the information in my health record may include information relating to sexually transmitted diseases (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of substance use disorders.

***State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained.***

☐ Yes ☐ No The diagnosis or treatment of substance use disorders.
☐ Yes ☐ No The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS).
☐ Yes ☐ No The treatment and/or consultation for mental health.

**Authorization**

I understand that I may inspect or copy my protected health information prior to use or disclosure as provided in CFR 164.524. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations and that if I use a general description of the entity receiving the records, upon request and consistent with 42 CFR Part 2, I must be provided with a list of entities to which my information was disclosed pursuant to the general designation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that authorizing this disclosure is voluntary. I may refuse to sign this authorization. Refusal to sign this authorization will not adversely affect my treatment. If I have questions about disclosure of my health information, I can contact BCHC. You are hereby authorized to furnish the requested protected health information, on the above patient, in accordance with the policy of your facility.

I also understand that this authorization may be revoked at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the facility. 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.

This consent will remain in force until _____, 20 _____, or on the happening of the following event or condition _____. If I fail to specify a date, event or condition this authorization will expire in six months.

Patient Signature: Date:

Signature of: Date:

☐ Parent ☐ Guardian ☐ Legal Representative (check one)

Note: if Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request.

Witness/Medical Staff: Date: