Authorization for Disclosure of Confidential Medical/Health Information

I, ____ authorize and request
(Name of Client, Parent, Guardian/Legal Representative)

the Clark Community Mental Health Center to ☐ Disclose/release TO ☐ Obtain/Receive FROM
the below specified information of:

______________________________ ____/____/____ ____-____-____
(Name of Client) (Date of Birth) (Social Security Number)

To/From:

____ ________________
(Name of Facility, Agency, Person) Phone #

____
(Address, City, State, Zip)

The Following Information: (select option **A** or **B**)

A. ☐ I authorize the release of <u>**ALL**</u> my complete health records (**including any** records that may contain information pertaining to mental health treatment, communicable diseases, HIV or AIDS <u>**and**</u> substance use treatment. (Sign below following **Note** if choosing option A).

Note: Alcohol and substance use records are specifically protected by federal regulations (42 CFR Part 2). By signing in the box below, I am allowing the release of any alcohol/or drug information records **(if any)** that I may have to the Facility, Agency or Person specified on this form. Prohibition of Redisclosure: Federal Regulations (42 CFR Part 2) prohibit the recipient of substance use treatment records from making further disclosure of those records without the specific written authorization of the person to whom those records pertain, or as otherwise specified by such regulation. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose. Sign below **if you wish to authorize** the release of **alcohol or substance use information.**

______________________________________ ____/____/____
(Signature of Client or Parent, Legal Guardian/Representative) (Date)

** OR **

B. ☐ I authorize the release of my complete health record with the exception of the following information: (Mark items you <u>do not</u> wish to release.)

☐ Mental Health Information

☐ Communicable Diseases (including HIV and AIDS)

☐ Alcohol/Drug Use Treatment

☐ Other (please specify) ______________________________________

For the purpose of: ______________________________________

Clark Center

PLEASE READ CAREFULLY:

1. I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition it may include information relating to sexually transmitted diseases, acquired immune deficiency (AIDS), human immunodeficiency virus (HIV), or other communicable diseases and alcohol /drug use if any.

2. Alcohol and drug use information records are specifically protected by federal regulations (42 CFR 2). By signing this authorization without restrictions indicated on the reverse side, I am allowing the release of any alcohol and/or drug information records (if any) to the facility, agency or person specified on this form.

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the Clark Community Mental Health Center while this authorization is in effect.

4. Unless otherwise indicated here, this authorization becomes effective on the date of the signature below and will expire one year from that date. (From: _____/_____/_____ To: _____/_____/_____)

5. I understand that I have a right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**

6. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact record staff members.

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so IN WRITING and present my written revocation to records staff. I further understand that actions already taken based on this authorization, will NOT be affected.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ, UNDERSTAND AND AUTHORIZE THE RELEASE OF MY PHI:

______________________________________ _____/_____/_____
(Signature of Client or Parent, Legal Guardian/Representative) (Date)

______________________________________ _____/_____/_____
(Witness) (Date)

NOTICE OF REVOCATION

I, ______________________________ (Client Name), hereby revoke my authorization of this disclosure of information to the agency/person listed on reverse side. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

______________________________________ _____/_____/_____
(Signature of Client or Parent, Legal Guardian/Representative) (Date)

______________________________________ _____/_____/_____
(Witness) (Date)