1401 South Arch Avenue, Suite A, Alliance, Ohio 44601 | Phone: 330-249-7011 | Fax: 330-823-8955

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

AUTHORIZATION

I _____, herby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

THE INFORMATION IS TO BE DISCLOSED BY:	AND IT TO BE PROVIDED TO:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE
PHONE FAX	PHONE FAX

THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment, or Other Healthcare Operations ☐ Personal Use ☐ Attorney ☐ School
☐ Disability ☐ Research ☐ Health Information Exchange ☐ Other (Specify): _____

THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD:

☐ Entire Record
☐ Only information related to (specify) _____
☐ Only the period of events from _____to _____
☐ Other (specify) (Billing, etc.). _____ If you would like any of the following sensitive information disclosed, check the applicable box(es) below:
☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS- related treatment
☐ Mental Health (other than psychotherapy notes) ☐ Sexually Transmitted Diseases
☐ Psychotherapy notes ONLY (by checking this box, I am waiving any psychotherapist-patient privileges)

AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to Alliance Family Health Center, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. I understand that Alliance Family Health Center will not condition treatment or eligibility for care on my providing this authorization. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by The Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164) and the Privacy Act of 1974 (5 USC 552a).

SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS:

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRSENTATIVE (State relationship to patient)	DATE (mm/dd/yyyy)
X	

PATIENT INFORMATION	NAME (Last, First, MI)	DATE OF BIRTH
ADDRESS	CITY/STATE	MRN