AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Birth Date:** _____

Maiden/Prior Names: _____ **Current Phone #:** _____

Current Address: _____ **Last 4 of SS#:** _____

For Fairmount to be released to or requested from:

☐ Self (address above)

☐ _____ _____

Name / Attention Street Address City State Zip Code

_____ (____)_____ (____)_____

Facility/Agency/Organization Telephone Number Fax Number

Via (only when released to): ☐ Verbal Exchange of Information ONLY

☐ Mail ☐ Fax ☐ Pick-up ☐ Secured Email: _____

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use

☐ Billing/Insurance ☐ Legal Investigation ☐ Academic ☐ Other: _____

Dates of Service Requested: _____

☐ I authorize the release of the following information **including** all records that include any substance use disorder and/or substance use disorder treatment records.

☐ I authorize the release of the following information **excluding** all records that include any substance use disorder and/or substance use disorder treatment records.

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Continuity/Transition of Care Packet ☐ Discharge Summary ☐ Lab/Diagnostic Reports

☐ Psychiatric Evaluation ☐ Progress Notes ☐ HIV Test Results / AIDS Treatment Records

☐ History and Physical ☐ Physician Orders ☐ Other: _____

This authorization will expire on 1 year from the date of signature:
This form must be completed in full before signing:

Patient's signature (required for ages 14 and older) : _____ **Date:** _____

Parent/Legal Guardian signature (if applicable): _____ **Date:** _____

Witness signature/Credentials: _____**Date:** _____

This authorization is intended to allow Fairmount to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. Subject to Mental Health Procedures Act 55.PA Code § 5100.34. F.1.This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains.

Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

You have the right to **revoke** this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed.

Revocation Signature: _____ **Date/ Time**: _____

For Verbal Consent see Part 2 on Back

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PART 2: **AUTHORIZATION FOR RELEASE OF INFORMATION**

VERBAL CONSENT

Verbal consent to release information is acceptable if the patient is physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent.

(Signature of Witness)	(Title or Relationship)	(Date)
(Signature of Witness)	(Title or Relationship)	(Date)

For Verbal Consent see Part 2 on Back