Unity MEDICAL CENTER
For Your Health

(Office use only) MRN: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

Address: _____ **Phone Number:** _____

City/ State/ Zip: _____ **Maiden/Previous Names:** _____

Release Information From:	***Release Information To:***
Name/Facility:	Name/Facility:
Address:	Address:
City/State/Zip	City/State/Zip
Phone:	Phone:

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING. (I specifically authorize the release of the following:)

☐ Psychiatric/Psychological _____ (Initials) ☐ HIV _____ (Initials) ☐ Drug and/or Alcohol Dependency _____ (Initials)

☐ **Two-Way** ongoing written/verbal for the above information

☐ **Check if applicable – Notice to Whomever Disclosure is made concerning addiction records.**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2, a general authorization for the disclosure 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 patients.

Information to be Released: **Service Dates: FROM:** _____ **TO:** _____

☐ Progress/Provider Notes
☐ Laboratory Reports
☐ Billing Information
☐ PT/OT/SLP Therapy
☐ Operative Report
☐ Other _____

☐ Immunization Record
☐ Current Medication List
☐ Emergency Room Record
☐ Discharge Summary
☐ Allergy Records

☐ X-ray Reports ☐ X-ray Films ☐ X-Ray CDs
☐ Push X-ray Images to PACS
☐ Advance Directives
☐ ADHD/ADD Testing, and Diagnosis
☐ Complete record (Hospital or Clinic). Please circle record type needed. (One year history unless otherwise specified)

For the following date(s) of treatment or condition: _____

Delivery Time Frame: **Date information desired by:** _____

Purpose: ☐ Continued care ☐ Personal use ☐ Legal ☐ Military ☐ Insurance/ Billing ☐ Wellness ☐ Worker's Comp ☐ Other _____

This authorization shall remain in effect until the following date, event or condition: _____
If no date, event or condition is specified, this authorization will expire in one year.

Release Format: _____Oral _____Written _____USB _____MyChart _____FAX Number: _____

This information remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. I understand that I may inspect, or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulation. A photocopy of this authorization is a effective as the original.

Signature (required) _____ **Date Signed (required)** _____

Printed Name of Person Signing (if not patient) _____