



Authorization for Release of Protected Health Information

Patient name: _____ Maiden/Prior Names: _____
Patient Date of Birth: _____ Current Phone #: _____ Last Four of SSN: _____
Current Address: _____

Direction of Disclosure:

I authorize CPH Behavioral Health to (check one or both):

☐ **RELEASE** information to the person/organization below ☐ **REQUEST** information from the person/organization below

Agency/Organization: _____ OR ☐ Self - (address above)
Telephone number: _____ Fax Number: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Name/Attention To: _____

Method of Disclosure:

☐ Mail ☐ Fax ☐ Pick-Up ☐ Verbal exchange of information

Purpose of Disclosure:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use ☐ Academic ☐ Legal Investigation
☐ Billing/Insurance ☐ 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, **or**

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

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

☐ Continuity/Transition of Care ☐ Psychiatric Evaluation ☐ History and Physical ☐ Discharge Summary ☐ Progress Notes
☐ Physician Orders ☐ Lab/Diagnostic Reports ☐ Treatment Plan and Records ☐ Other: _____

This authorization will expire on ____/____/____. (If not indicated, authorization will expire one year from signature date).

This form must be completed in full before signing.

Patient Signature: _____ **Witness Signature/Credentials:** _____
Date: _____

This authorization is intended to allow Central Peninsula Hospital: Behavioral Health 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), and 45 CFR 160 and 164. 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 from such re-disclosure.

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. Signing this authorization is voluntary. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not a condition on signing this authorization. A photocopy or electronic copy of this signed authorization is valid as the original.

Revocation Signature: _____ Date/Time: _____