

Authorization to Use and Disclose Protected Health Information



Patient's Name: _____ Dates of Treatment: _____

Address: _____
(Street) (City) (State) (Zip)

DOB: _____ SS#: _____ Phone: () _____

I acknowledge and hereby consent to release information from my health record including psychiatric and alcohol/drug abuse treatment information. I understand that my records are protected under Federal and State regulations governing the confidentiality and privacy of health information under CFR 45, CFR 42 Part 2, FS 394, 397, 381 and 90.503 cannot be disclosed without my written authorization unless provided for by the regulations. I further understand that the disclosed information may contain additional information pertaining to the following:

- Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV) _____ (initial)
- Sexually Transmitted Diseases (STDs) _____ (initial)
- Drug and Alcohol Treatment and or Referral for Treatment _____ (initial)

Please check the information you want disclosed:

- | | | |
|---|--|--|
| <input type="checkbox"/> Discharge/Continued Care Summary | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Labs & X-Ray Results | <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Medication Evaluation |
| <input type="checkbox"/> Dates of Treatment Letter | <input type="checkbox"/> Other (Please specify): _____ | |

I authorize PEMHS, Inc. to make disclosure to the individual or organization identified below:

(RELEASE TO) (RECEIVE FROM) (EXCHANGE WITH)

----- Please circle one of the above -----

Name: _____ Relationship: _____

Telephone: _____ Fax Number: () _____

Address: _____

City: _____ State: _____ Zip Code: _____

Type of Disclosure: Written Verbal Fax Electronic

The information that I am authorizing for disclosure will be used for the following purpose:

- | | | | | |
|---|------------------------------------|---|--|--|
| <input type="checkbox"/> Continuity of Healthcare Treatment | <input type="checkbox"/> Education | <input type="checkbox"/> Insurance/Disability | <input type="checkbox"/> Legal Reasons | <input type="checkbox"/> My Personal Records |
| <input type="checkbox"/> Other (Please specify): _____ | | | | |

This consent will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire automatically in one year.

I understand that:

- I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at:
 - 11254 58th Street North, Pinellas Park, FL 33782 (I understand that the revocation will not apply to information that has already been disclosed in response to this authorization).
- If the requester or receiver is not a health plan or healthcare provider, then the disclosed information may no longer be protected by Federal Privacy Regulations and may be re-disclosed.
- I am entitled to receive a copy of this authorization.
- I may refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.
- I hereby release PEMHS, Inc. from liability, which may arise as a result of information disclosed under this authorization if such information is later used to my detriment.

Signature of Patient/Guardian/Representative (circle one): _____ Date: _____

Signature of Patient's Legal Representative (if applicable): _____ Date: _____

If signed by Legal Representative, Relationship to the patient: _____

Proper documentation establishing relationship is provided (specify documentation): _____

Signature of Witness: _____ Date: _____

11254 58th Street North, Pinellas Park, FL 33782: PHONE: (727) 545-6477; Release of Information FAX: (727) 549-6074

PATIENT NAME: _____

MEDICAL RECORD #: _____

SW 003 (10/04 Rev: 09/2015)

Comment [KL1]: This is the client's information you are trying to obtain.

Comment [KL2]: If these apply to the client, the client must initial each applicable item, otherwise information containing these subjects will not be release.

Comment [KL3]: Type of information you want to disclose to the listed individual or agency. If you would like all clinical information, mark other and indicate all.

Comment [KL4]: "Release to" is for PEMHS to release to an agency/person. "Release from" is for an outside agency to release information to PEMHS. "Exchange with" is for PEMHS and the agency to share health information.

Comment [KL5]: Enter the information for the person or agency you wish to receive the client's medical records from PEMHS. This is where the requested records will be disclosed to.

Comment [KL6]: Choose method of release, at this time we cannot perform electronic.

Comment [KL7]: Provide the purpose for requesting the client's health information.

Comment [KL8]: There must be a signature and date. If a minor who received mental health treatment, the guardian must sign instead. If minor received substance abuse treatment (JARF/Marchman Acted), the minor must sign and date. If the client is unfit to consent, the requestor must provide legal proof to make medical decisions for the client (will need to attach copy of court order, power of attorney, etc.)