AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden / Prior Names: _____ Current Phone #: _____
Current Address: _____

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

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Academic
☐ Legal Investigation ☐ Other: _____

I authorize the release of the following type of record *(initials required)*: _____Mental Health Treatment Records
_____Alcohol and Drug Abuse Treatment Records
_____HIV Test Results and AIDS Treatment Records

I **authorize the release of the following specific documents / information:**

☐ Comprehensive Assessment (Intake, Nursing, Psychosocial, and Psychiatric Assessments)
☐ History and Physical Examination
☐ Physician's Orders
☐ Lab / Diagnostic Reports
☐ Progress Notes
☐ Medication Records (DC Medication Orders, MAR)
☐ Discharge Summary
☐ Aftercare / Discharge Plan
☐ Other: _____

To be released by:

☐ Cedar Hills Hospital / Cedar Hills Outpatient Services
☐ _____ (____)_____ _____

Agency / Name | Telephone Number | Address | City | State | Zip Code

To be released to:

☐ Cedar Hills Hospital / Cedar Hills Outpatient Services
☐ _____ (____)_____ _____

Agency/Name | Telephone Number | Address | City | State | Zip Code

Allowable method(s) for the release of information: ☐ Mail ☐ Verbal ☐ Pick-Up ☐ Fax (Fax #: _____)

Authorization expiration: ____/____/20____. (If not indicated, authorization will expire 365 days (1 year) from signature date).

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. You have a right to inspect and receive a copy of the information that is to be disclosed. 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 information in the processing of this request.

This form must be completed in full before signing:

_____ _____ _____
Patient's signature | Parent / Guardian signature (if applicable) | Relationship to Patient

_____ _____
Witness signature | Date Signed

This authorization is intended to allow Cedar Hills Hospital / Cedar Hills Outpatient Services 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) or the STATE MENTAL HEALTH ACT is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. Cedar Hills Hospital / Cedar Hills Outpatient Services is not liable for such re-disclosures.