The Center for Health Care Services

AUTHORIZATION FOR DISCLOSURE, USE, OR RECEIPT OF PROTECTED HEALTH INFORMATION

Consumer Name: _____

Case#: _____

Program/Unit: _____

Sub Unit #: _____

You have the right to refuse to sign this authorization. The Center for Health Care Services will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign the authorization. You will receive a copy of this signed authorization.

Date of Birth: _____ **Social Security Number:** _____

I authorize the designated staff at _____ **to disclose/use/receive the following**
(name of organization or individual)

protected health information about me (in any form, including verbal, written and electronic) for the time period of _____ **to** _____**. Check all that apply:**

- ☐ Physician/Medication Orders
- ☐ Lab/X-Ray Reports
- ☐ HIV/AIDS Information
- ☐ Nursing Notes
- ☐ Physician Progress Notes
- ☐ DMR/ CD&E Reports
- ☐ Counseling Notes
- ☐ ARD/IEP
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan/Treatment Reviews
- ☐ Alcohol/drug Abuse Treatment Information
- ☐ Discharge Summary
- ☐ Immunization Record
- ☐ Academic Record/Transcript
- ☐ Assessments: Psychological, Nursing, Speech-Language, OT/PT, Social, Educational, Vision, Hearing, & Vocational
- ☐ Other, specify and include dates: _____.

The facility's designated staff may disclose to/receive from the following individual, organization or facility:

Name: _____ **Address :** _____

City: _____ **State:** _____ **Zip Code:** _____ **Fax #:** (___)_____ **Phone #** (___)_____

The disclosure/use is for the following purpose(s):

- ☐ to coordinate my discharge/referral/placement
- ☐ to assist in educational placement/planning
- ☐ to assist with funding
- ☐ to assist in securing/maintaining employment/housing
- ☐ research
- ☐ to give information about my treatment and services
- ☐ at my request
- ☐ Other, state: _____.

Note: **If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.**

Note: **If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family.**

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the facility, except to the extent that the facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier it will expire 90 days from the date signed by the consumer or legally authorized individual, or as otherwise specified by date, event or condition of expiration: _____.

_____ _____
Signature of Consumer **Date**

_____ _____ _____
Signature of Legally Authorized Individual **Relationship** **Date**

A photocopy or facsimile transmission is as valid as the original

(Note: For individuals receiving alcohol or drug abuse treatment, this form serves as the consent required by 42 CFR § S.31.)