AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ **Date of Birth:** ________________

Address: ____

Home/Cell Phone: (_______)________________________ **Work Phone:** (_______)_______________________

I, the undersigned patient or legal guardian, hereby authorize verbal ❐ and/or written ❐ information to be released by:

____
Name of Releasing Facility/Provider

____
Mailing Address

To:

____ ( ) ______________ ( ) ______________
Name of Hospital/Clinician/Third Party Phone Fax

____
Mailing Address

Information to be released:

❐ Psychiatric Evaluation
❐ Medication Record
❐ H&P/Lab work
❐ Psychosocial
❐ Psychological Testing
❐ Treatment Planning
❐ Discharge & Aftercare Plan
❐ Progress Notes

❐ Other (specify) ____

Release of information for the following purpose(s): ❐ Treatment/Consultation ❐ Patient Request ❐ Billing/Claims

❐ Attorney ❐ Other (specify) ____

- I understand that the information released may be ***(Initial for release of the following information)***:
  ________Mental Health ________Substance Abuse ________HIV/AIDS information.
- I understand that this authorization is voluntary and that treatment by a Meier Clinics® provider cannot be conditioned on the signing of this authorization.
- I understand there may be a charge, payable in advance, for the copying and conveyance of records released.
- I understand that this authorization can be withdrawn by me in writing at any time. I cannot, however, take exception to actions that had taken place before I withdrew my consent.
- I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected. Meier Clinics® and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the information which is being released is from records whose confidentiality is protected by State and Federal Law.
- I understand I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law. I also have the right to refuse to sign this authorization.
- Refusal to sign this form will result in the following consequences**: Information will not be disclosed/obtained.**
- I understand this authorization will expire on________________________(enter date or event)

____ ______________________
Patient (must be signed by patient if 12 years or older) or Date
Legal Representative (description/proof of authority to act for patient must be provided)

____ ______________________
Witness and Title/Relationship to Patient Date

Notice To Whomever Disclosure is made: This information has been disclosed to you from records whose protected health information is protected by State and Federal Law, including 42 CFR Part 2. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom **it pertains.**