

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Use this form if the Client requests ongoing release OR if request is from someone other than the client or their legal representative

Client Name: \_\_\_\_\_ D.O.B.: \_\_\_/\_\_\_/\_\_\_ Client #: \_\_\_\_\_

I authorize South Central Human Relations Center to **send**  **request**  the private data specified below to/from:  
(A fee may be charged)

Name/Entity/Category: SCHRC

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ Encrypted:  I understand the risk and request unencrypted:

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ HIE/PHR \_\_\_\_\_

Information to be Released: Ongoing  or Date from \_\_\_\_\_ to \_\_\_\_\_ or specific visit date: \_\_\_\_\_

- |  |  |   |   |
|--|--|---|---|
| <input checked="" type="checkbox"/> Assessment/Evaluation        | <input checked="" type="checkbox"/> Testing Results            | <input checked="" type="checkbox"/> PSI/Police Report   | <input checked="" type="checkbox"/> Labs/Meds/Allergies |
| <input checked="" type="checkbox"/> Progress Notes               | <input checked="" type="checkbox"/> Verbal Information         | <input checked="" type="checkbox"/> Admission/Discharge/Transfer Alerts                               |   |
| <input checked="" type="checkbox"/> Letter(s)                    | <input checked="" type="checkbox"/> Healthcare Provider Portal | <input checked="" type="checkbox"/> Other (specify) <u>collateral data and treatment coordination</u> |   |
| <input checked="" type="checkbox"/> Continuity of Care Doc (CCD) |  |   |   |

You must specifically request the following for it to be released:

- Chemical Dependency Program  
 Psychotherapy Notes (conversational analysis) No other items can be checked when requesting this item

Reason:  Assessment and Treatment Planning  Continuity of Care  
 Other (specify, e.g. legal, appeal SS Disability) Collateral data and treatment coordination

Valid for: One year  or for this specified period: \_\_\_\_\_

This authorization **does**  **does not**  extend to information placed in my record after the date I sign this form.

- I understand that my records to be released may contain information regarding substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information.
- I understand that I have the right to revoke this authorization by signing "I revoke..." below and returning to SCHRC. If South Central Human Relations Center has already released information based on this consent, we cannot retrieve what has already been released.
- I recognize that the protected health information used or disclosed according to this authorization may be re-disclosed by the recipient and SCHRC can no longer protect it.
- I understand that I may refuse to sign this consent, if I so desire, and that SCHRC may not refuse treatment if I do not sign, but refusal may have consequences that have been explained to me.

**Signature:**

Indicate if you are: Client, Parent, or Personal Representative (Provide legal proof if representative not parent) \_\_\_\_\_ Date \_\_\_\_\_

Type of identity verification \_\_\_\_\_

I **revoke** this authorization: \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_