Authorization to Disclose Health Information

Pines Health Services
74 Access Highway
Caribou, Maine 04736

Patient's Printed Name: ________________________________ **Date of Birth:** _____________

Address: _________________________City: ______________ State: ________ Zip: ___________

Phone: _________________ 2nd __________________

<u>IMPORTANT NOTICE</u>: *If this authorization form is used to authorize either (i) the disclosure of psychotherapy notes, (ii) the disclosure of substance use disorder counseling notes, or (iii) the disclosure of substance use disorder (Part 2) program information or records in a civil, criminal or administrative proceeding, it can only be used for <u>one</u> of these purposes and cannot also be used to authorize the disclosure of other types of health information or records for other purposes on this same form. Separate authorizations forms must be completed and used for other types of disclosures.*

By signing below, I hereby authorize **Pines Health Services (PHS) and my PHS health care provider(s)** (*check applicable box*) to:

❑ DISCLOSE to:

____

Person(s)/Entity(ies) Address Phone Fax

❑ OBTAIN from:

____

Person(s)/Entity(ies) Address Phone Fax

the following health care information and/or records about me (*check all that apply*), including the types of information I have initialed in the next section below:

- ❑ My complete medical or clinical records, i.e., all health care information and records relating to my health care, treatment and services maintained by the disclosing party identified above.
- ❑ My complete clinical records for the dates: _____/_____/_____ to _____/_____/_____.
- ❑ The following specific records or information: ____
  ____
  ____

I specifically intend this authorization to include the disclosure of the following types of records and information maintained by the disclosing party identified above **(*initial as applicable*):**

[____] **Psychotherapy notes** as defined at 45 C.F.R. §164.501 of the HIPAA Privacy Standards. *If checked or initialed, no other type of disclosure may be authorized on this same form.*

[____] **Mental health information and records (other than psychotherapy notes) maintained by licensed mental health agencies, facilities or programs.** *I understand that I have the right to review any mental and behavioral health records maintained by licensed mental health agencies, facilities or programs at any reasonable time before deciding to authorize their disclosure.*

[____] **Health care information (other than psychotherapy notes) derived from mental health**

services provided by licensed mental health professionals (i.e., psychiatrists, psychologists, clinical nurse specialists, social workers and counseling professionals). This option must be checked or initialed to authorize Pines to disclose this type of mental health information *in a non-emergency* to another health care practitioner or facility for diagnosis, treatment or care, or to complete the responsibilities of a health care practitioner or facility that provided diagnosis, treatment or care.

[____] **Substance use disorder program records and information** subject to protection under 42 C.F.R. Part 2. *If this authorization is being used to authorize disclosure of substance use disorder (Part 2) program information or records in a civil, criminal or administrative proceeding, no other type of disclosure may be authorized on this same form. I also understand that if the recipient of my Part 2 information is a HIPAA covered entity or business associate and is receiving my Part 2 information for purposes of treatment, payment, or health care operations, the recipient may redisclose my Part 2 information in accordance with the permissions contained in the HIPAA regulations (45 C.F.R. Parts 160 and 164), except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.*

[____] **Substance use disorder counseling notes** as defined at 42 C.F.R. §2.11. *If checked or initialed, no other type of disclosure may be authorized on this same form.*

[____] **HIV (Human Immunodeficiency Virus) test results and medical records documenting HIV test results and HIV infection status.** *I understand that there are potential implications and adverse consequences of authorizing the disclosure of HIV information and records, including the potential loss or denial of employment, health insurance benefits, life insurance benefits, and/or other forms of discriminatory treatment, whether lawful or unlawful.*

[____] The following **specific types of health care information:** ______________________________
____

Unless I strike out any of the following, I intend this authorization to include (i) disclosure of records and information the disclosing party has received from other health care providers or facilities, and (ii) subsequent disclosures of information within the scope of this authorization (i.e., I authorize the disclosing and recipient parties of my health care information identified above to have continuing communications concerning the health care information authorized to be disclosed by this form, and to exchange information covered by this authorization that was created or related to clinical encounters occurring after the date of my signature below) for as long as this authorization remains in effect. I authorize Pines Health Services and my Pines Health Services provider(s) to disclose or receive the above records or information by fax, mail, verbally, or by other means, as deemed most appropriate by the disclosing and/or recipient parties.

I authorize the disclosure of the above information for the following purpose(s):

☐ Transfer of Care Reason: ____
☐ Treatment, payment, and health care operations ☐ At my request
☐ Treatment, referral, coordination and/or continuity of care ☐ Legal matter or proceeding
☐ Other purpose (*specify*): ____

Duration of Authorization: This authorization will remain in effect for one year with respect to any disclosures of mental health information by a licensed mental health agency, facility or program authorized on this form, and for 30 months for any other disclosures authorized on this form, from the date of my signature below, unless I either revoke it or enter an earlier **Expiration Date or Event** here: ____.

By signing below, I acknowledge that I have read this authorization and understand that:

- Pines Health Services may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

- I may refuse to authorize the disclosure of some or all the above health care information but that my refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- There is the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected.
- I may revoke this authorization at any time, either orally or in writing, by notifying Pines Health Services at the address, telephone or fax number above, or in the manner described in Pines Health Services' HIPAA Notice of Privacy Practices, subject to the right of any person who acted in reliance on this authorization prior to receiving notice of my revocation. I understand that my revocation may be the basis for denial of health or other insurance coverage or benefits.
- I am entitled to a copy of this signed authorization form.

__________________ ____

Date Printed Name of Patient or Authorized Representative

____

Signature of Patient or Authorized Representative** *** Signature by authorized representative constitutes a representation that the person has the legal authority indicated below.*

Authorized Representative's Legal Authority:

☐ Court-appointed guardian
☐ Health care power of attorney agent
☐ Health care surrogate
☐ Other (*specify*, e.g., personal representative of deceased patient's estate; parent, guardian or *guardian ad litem* of a minor): ___________________________

NOTICE TO RECIPIENTS OF PART 2 PROGRAM RECORDS/INFORMATION: If this authorization form authorizes the disclosure of Part 2 Program records, 42 C.F.R. Part 2 prohibits unauthorized disclosure of these records/information.

For Pines Health Services Internal Office Use Only

Date Patient's Authorization Received by PHS: ________________ ___________
Staff Initials

Date Patient's Records/Information Disclosed by PHS: ________________ ___________
Staff Initials

☐ If PHS disclosed Part 2 Program records/information pursuant to this Authorization, PHS included with the disclosed records a copy of this Authorization Form (includes the Part 2 Notice Statement) as required by 42 C.F.R. §2.32(a)-(b).

☐ If requested records/information disclosed are partial or incomplete, notification provided to recipient by (*specify manner of notification*): ____

Date Patient's Records/Information Received by PHS: ________________

Date of Patient's Revocation of Authorization: ________________

Manner of Revocation: ____

Date: ________________ ____
Signature of PHS Staff Member Processing Patient's Authorization