AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

SUBSTANCE USE DISORDER

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of Client: _____

Date of Birth: _____ MR#/Case#: _____

RELEASE FROM

Name/Entity: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

RELEASE TO

Name/Entity: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

USE AND DISCLOSURE OF INFORMATION

Specific Description of Information to be Released:

[describe how much and what kind of information may be disclosed, including a clear description of any substance use disorder information to be disclosed; should be as limited as possible]

_____

_____

PURPOSE

[Please state the purpose for the disclosure. In accordance with §2.13(a), the disclosure must be limited to that information which is necessary to carry out the stated purpose.]

_____

5957 S. Mooney Blvd., Visalia, CA 93277 · 559.624.8001 · tchhsa.org

EXPIRATION

[Please identify the date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is provided.]

MY RIGHTS

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that to the extent it is permitted by law, I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. 42 CFR Part 2 prohibits unauthorized disclosure of these records.

I may revoke this authorization in writing or verbally, by contacting the clinic providing my health services or to the Tulare County Health and Human Services Attn: Office of Compliance, 5957 S. Mooney Blvd., Visalia, CA 93277. I have a right to receive a copy of this authorization.

SIGNATURE

Signature: _____ Date: _____

Print Name: _____

If signed by other than client, indicate relationship: _____