



# AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

**Return Authorization to an Office Location by:**

Send Records to P.O. Box 8970, Toledo, Ohio 43623-0970 for:

Harbor Patient ID #: \_\_\_\_\_

Site Name (Secor, North Prospect, etc.): \_\_\_\_\_

Patient Full Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dates of Services (Disclosure for a specific time period) *Choose One:*
 Most Recent Episode/Admission   
  All Admissions/Episodes   
  Previous Six Months

 Other (Specify) \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
 (Date Required) (Date Required)

I hereby authorize Harbor to:   
  Obtain from   
  Release to   
  Share/discuss with  
 Information to be shared can be:   
  Verbal only   
  Written Records Only   
  Verbal and Written Records

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Check the following information to be released for the dates of service indicated above. The disclosure may include paper, oral and electronic interchange.

Entire Medical Record (*Does not include HIV/AIDS Testing, Genetic Testing Information or Drug & Alcohol Information. To authorize the disclosure of this information, you must also check below.*)

<input type="checkbox"/> Alcohol & Other Drug Diagnosis/Treatment Information	<input type="checkbox"/> HIV/AIDS/ARC Information	<input type="checkbox"/> Genetic Testing Information
<input type="checkbox"/> Diagnostic Assessment	<input type="checkbox"/> Psychiatric Diagnostic Evaluation	<input type="checkbox"/> Peds Consultation/Notes
<input type="checkbox"/> Psychological Testing Evaluation Report	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Billing Statement
<input type="checkbox"/> Medications	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> EAP Assessment
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Diagnoses	<input type="checkbox"/> EAP Notes
<input type="checkbox"/> Attendance	<input type="checkbox"/> Urine Screens/Lab Results	<input type="checkbox"/> EAP Discharge
<input type="checkbox"/> Other (must specify): _____		

Purpose(s) of Disclosure:   
 Coordination & Continuity of Treatment   
 Family Involvement   
 Personal   
 Legal  
 Insurance   
 Transfer from Practice   
 Aftercare/Follow-up  
 Other (explain/identify): \_\_\_\_\_

**CONFIDENTIALITY RULES:** This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. This Authorization to Disclose/Obtain Confidential Information will expire upon the date, condition, or event listed below:

Expiration date (cannot be dated beyond 12 months): \_\_\_\_\_ Condition/event of expiration: \_\_\_\_\_

- I understand that if the recipient of the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such recipient and will likely no longer be protected by federal privacy regulations. I understand that Harbor cannot control the recipient's use of the disclosed information.
- I understand that authorizing the use or disclosure of the above information is voluntary. I understand Harbor will not condition about treatment, payment, enrollment, or eligibility for benefits on the execution of this authorization.
- I understand that I can revoke this authorization at any time, except to the extent that action has been taken by Harbor in reliance on this authorization, and that the revocation must be signed and dated by me. Upon revocation of this authorization, further release of information shall immediately cease.
- For more information about your privacy rights, please refer to Harbor's HIPAA Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative\_\_\_\_\_  
Print Name\_\_\_\_\_  
Date\_\_\_\_\_  
Relationship of Authorized Representative (if applicable)\_\_\_\_\_  
PRINT Name of staff member facilitating this request.\_\_\_\_\_  
Signature of Minor Client (For AOD Records Only)\_\_\_\_\_  
Date**I hereby REVOKE my consent for the release of the above information.**\_\_\_\_\_  
Signature:\_\_\_\_\_  
Date:\_\_\_\_\_  
Relationship to Client: