MEDICAL AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Participant Name: YOUR NAME	**Date of Birth #:** YOUR DATE OF BIRTH

I, YOUR NAME, authorize and consent that
(Participant/ Patient Name)

HealthRIGHT360, Lyon-Martin Health Services and Women's Community Clinic; Phone 415-565-7667
(Clinic Name and Address)
1735 Mission Street, San Francisco, CA 94103; Fax 415-252-7512
can exchange and disclose my health information, including substance use disorder information, to:
NAME, ADDRESS, PHONE NUMBER AND FAX OF OTHER INDIVIDUAL/ORGANIZATION
(Specific Name of Organization/Individual), Relationship, Address and Telephone Number)

for the specific purpose(s) of: PERSONAL USE (if records are being release to you) or CARE COORDINATION (if records going elsewhere)
(Purpose for Authorization – please be as specific as possible)

- ☐ **FOR COMMUNICATION** allows us to discuss your care with other location
- ☐ **SENDING DOCUMENTS** allows us to send records TO other location
- ☐ **RECEIVING DOCUMENTS** allows us to receive records FROM other location

This Authorization includes only the following information: YOU MUST CHECK OFF ALL THAT APPLY

- ☐ Substance Use Disorder Summary
- ☐ Substance Abuse Treatment Plan
- ☐ Verification of Program Participation
- ☐ TB Results
- ☐ Intake/Assessment Summary
- ☐ Physical Exam Results
- ☐ Current Medications
- ☐ Diagnoses
- ☐ Discharge Summary/ Information
- ☐ **Dental Records:**
  Circle the following: ALL
  X-Rays Photographs and Models
- ☐ Mental Health Summary
  from (date)____ to (date)_____
- ☐ Mental Health Treatment Plan
- ☐ Medical Treatment Plan
- ☐ Test/Lab Results
- ☐ Immunization Records
- ☐ Medical Summary
- ☐ UA Results
- ☐ Emergency Contact
- ☐ Billing Records

MARKING "other: all medical records" WILL NOT ACCEPTED

- ☐ Other, Please Specify Lab results for HIV, STI testing or pap smears MUST BE SPECIFIED HERE

I understand that my health records are protected under the federal regulations governing Confidentiality and 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. pts 160 & 164, and cannot be disclosed without my written Authorization unless otherwise provided by the regulations.

I further understand that:

- I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it. The revocation must be made in writing.
- I am entitled to a copy of this Authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

MEDICAL AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Unless I revoke my Authorization earlier, I understand that this Authorization will remain in effect until:

THE DATE THIS SHOULD EXPIRE
____
(Date Authorization expires;)

I have had an opportunity to review and understand the content of this Authorization. By signing this form, I am confirming that it accurately reflects my wishes.

YOUR NAME AND SIGNATURE ______________________ DATE ______________________
(Participant Name & Signature) *(Date)*

______________________ ______________________
(Staff Name & Signature) *(Date)*

Describe Personal Representative's Relationship to Participant:

____

DO NOT WRITE ANYTHING BELOW THIS LINE UNLESS YOU ARE CANCELLING THE RELEASE

REVOCATION OF AUTHORIZATION

The federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance and Portability Act of 1996 ("HIPAA") provide an individual the right to revoke a previous Authorization to disclose information. By completing this below mention section, you are requesting a restriction to any further disclosures of your personal health information.

I, ______________________________________, hereby revoke the Authorization to
(Participant Name)

release my confidential health records effective, ______________________________.

I understand that the revocation will only apply to future disclosures or actions regarding my personal health information and cannot cancel actions or disclosures made while the Authorization was previously in effect and valid.

______________________ ______________________
(Client Signature) *(Date)*

______________________ ______________________
(Staff Signature) *(Date)*

NOTICE REGARDING THE RELEASE OF CONFIDENTIAL SUBSTANCE USE DISORDER INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written Authorization of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.