Authorization RECEIVED

Date: _____

Staff Name *(Printed)*: _____

Authorization REVOKED on: _____

❑ Verbally by client ❑ In writing by client

Staff Signature: _____

Authorization to Release Protected Health Information (PHI)

Clients' Name: _____ (Last Name) _____ (First Name) _____ (MI) Date of Birth: _____

The following person and/or entity is authorized to: ❑ DISCLOSE ❑ RECEIVE the specified information

Name/Entity/Title _____

Address City State Zip _____

Phone Number: | Fax:

This information is to be used for the following purpose(s) only:

❑ Continuity of Care/Coordination ❑ Educational ❑ Disability Claim

❑ Family Communication ❑ Attorney/Legal ❑ Compliance with Terms of Parole and Probation

Information to be released and/or disclosed by:

▱Written & verbal exchange **□ Verbal exchange only** **□ Written exchange only**

Specify information to be released and/or disclosed below:

___Full-Service record, including all SUD services, OR

Initial next to specific information to be released and or disclosed from the options listed below:

____ All Intellectual Developmental Disability (I/DD) records or
____ Specific I/DD records:
_____

____ All Educational (ED) records or
____ Specific ED records:
_____

____ All Medical (MM) records or
____ Specific ED records:
_____

____ All Psychiatric records (including labs) or
____ Specific Psych records:
_____

____ All records to assist in conducting Case Management or
____ Specific CM records:
_____

____ All Mental Health (MH) Records or
____ Specific MH Records
_____

____ All Substance Abuse (SUD) Records (including UA & swab results) or
____ Specific SUD records:
_____

____ All information necessary to deal with an Emergency.
____ Information necessary to arrange transportation.
____ All Crisis Assessment and Crisis Follow-up Services
____ HIV/AIDS Information

___ Other Information to be released/disclosed:

_____
_____
_____

Initials: ____ I understand Lifeways has an electronic health record which allows mental health staff access to information related to substance use or treatment or any other services I receive from Lifeways; I am therefore authorizing Lifeways staff members who need access to my protected health information to access the minimum necessary information in my record for such purposes. This is with the assurance that my substance abuse treatment information will not be reviewed in detail and the fact that I am receiving substance abuse treatment will not be disclosed to other programs outside of Lifeways without my explicit written authorization unless required by law.

Initials: ____ I understand I may revoke this authorization at any time by notifying Lifeways in writing or verbally, except to the extent that information has already been released in response to this authorization. I understand that there is a potential for information disclosed under the terms of this authorization to be redisclosed by the recipient and this redisclosure may no longer be protected by 45 C.F.R. 164, subpart E or applicable State law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition, _____. If I fail to specify an expiration date, this authorization will expire at the end of Lifeways services/treatment.

Initials: ____ I have read and understand the terms of this Authorization to Disclose, Receive, and Use Protected Health Information. By my signature below, I voluntarily authorize disclosure, receipt, and use of my protected health information as indicated above. I understand that the information disclosed using this authorization may be subject to re-disclosure and will no longer be protected by federal law. Refusal to sign this authorization will not adversely affect a person's ability to receive services and Lifeways may not condition payment, enrollment or eligibility for benefits on whether I sign this authorization. If this Release is generalized, I can request a list of entities to which my information has been disclosed.

Signature of ❑ Patient or ❑ Legal Representative: **Date:**

Name of Guardian/Legal Representative (if applicable) *(Please Print)*: **Describe authority to act for patient:**

Clients 14 years or older are required to sign in order for this release of information to be valid.

**Information disclosed from any alcohol and drug abuse treatment records is protected by federal confidentiality rules (42 CFR part 2 and 45 CFR parts 160 and 164). Federal rules prohibit anyone 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 release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of alcohol and drug treatment information released for criminal investigations or prosecution purposes.*