EAST END
BEHAVIORAL HEALTH HOSPITAL

RELEASE OF INFORMATION

POLICY NUMBER: HIM 32.001	DEPARTMENT: HIM	REVISION DATE: 02/03/2023

(Insert Facility/Hospital Name and Address)

Please read this entire form before signing and complete all sections that apply to your decisions relating to the release or disclosure of your protected health information.

Covered entities as that term is defined by HIPAA must obtain a signed authorization from the individual or the individual's legally authorized representative to release or disclose that individual's protected health information in many circumstances. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment of services, or enrollment or eligibility for benefits. **An incomplete form cannot be processed and may be returned to you to obtain the required information.**

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE**(_____)_____

EMAIL ADDRESS (Optional):_____

I AUTHORIZE THE FACILITY/PERSON/ENTITY BELOW TO RELEASE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Releasing Facility/Person/Entity _____
(Custodian of the PHI/Medical Record)

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION? (Party we are releasing to)

Person/Organization Name _____ _____

Address _____

City _____ State _____ Zip Code _____

Phone (_____)_____Fax (_____)_____ _____

Email address if requesting electronic transmission:

REASON FOR DISCLOSURE
(Choose only one option below)

- ❑ Treatment/Continuing Medical Care
- ❑ At the request of the individual
- ❑ Billing or Claims
- ❑ Insurance
- ❑ Legal Purposes
- ❑ Disability Determination
- ❑ School
- ❑ Employment
- ❑ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want released. Your medical record may contain **references** to HIV/AIDs, psychiatric diagnoses, or drug or alcohol use upon release, and your signature below authorizes release of that information when it is not maintained in a specifically designated specialty record

❑ History & Physical	❑ Discharge summary	❑ Operative/Consult reports	❑ Entire Medical Record
❑ Physician's orders	❑ Lab and Pathology reports	❑ Diagnostic test reports	❑ Itemized Bill
❑ Progress notes	❑ Radiology reports	❑ Medication Records	❑ Other information_____

Your initials are required to release the following information:

_____ Mental Health Records from a designated psychiatric provider

_____ Genetic Information (including Genetic Test Results)

Please choose one method of receipt of information:

- ❑ Paper copy
- ❑ Electronically burned to a CD/DVD
- ❑ Accessible at a secure electronic transmission site (requires computer internet access by the recipient)

-EFFECTIVE TIME PERIOD. This form is valid until i) the authorization is revoked in writing; ii) the following specific date: Mo. ____Day ____ Yr _____, or iii) for a period of 5 years from the date of signature if no specific date is provided. The authorization expires at the time of the individual's death **if** signed prior to their death.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization
to the facility listed above as the custodian of the protected health information (PHI) and to the receiving entity(s). I understand that prior actions taken in reliance on this authorization by entities that had permission to access, use, acquire or disclose my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses, accesses, acquisitions, and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE _____ **Date** _____

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Signature of Individual or Individual's Legally Authorized Representative

Printed Name of Legally Authorized Representative (if applicable) _____**Phone** _____

Specify relationship to the individual: ❑ Spouse ❑ [illegible] ❑ Guardian ❑ Proxy (Colorado only) ❑Other _____

(Please submit copies of any Power of Attorney, Guardianship, Executor or Administrator of Estate paperwork with this form).

Resources:

HIPAA
HiTECH
Joint Commission (IM.01.01.01, IM.02.01.01, IM.02.01.03, IM.02.02.01, IM.02.02.03)