Patient MRN:_____

OnCall Health Living Program
51 Locust Street
Northampton MA 01060
P:413-584-7425 | F:413-584-7440

AUTHORIZATION TO DISCLOSE PROTECTED PATIENT HEALTH INFORMATION

This form is used to authorize release of protected health information. Complete all <u>required</u> sections (➲).

➲Patient's Full Name:		➲Patients Date of Birth:	

➲ Below choose on how OnCall and Party A can share or exchange the Patient's Protected Patient Health Information and Personally Identifiable Information, verbal, written, or otherwise (altogether "Patient Record").	
➲ Party A Name:	
➲ Address:	
➲ Phone:	➲ Fax:

➲Patient Record | Choose the Patient Record(s) to be disclosed (choose all that apply):

☐	Complete Medical Record	☐	Program/Treatment Adherence
☐	Dosage Verification	☐	Labs, Urine Screens & Confirmation Testing
☐	Treatment Verification	☐	Medical Emergency Response Information
☐	Billing Information	☐	Appointment and Scheduling
☐	Other – Describe the "Other" record type to be shared:		

Purpose of Patient Record | Patient Record(s) chosen above will be used for (briefly describe):
COORDINATION OF CARE

Other:_____

➲Dates of Patient Record(s) To Be Released:	➲From:	➲To:

***<u>Specifically Protected or Privileged Information</u>*:**

I request the release of the specific categories of information that I have INITIALED below:

_____ HIV Test Results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST)

_____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2. FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.

_____ Details of Mental Health Diagnosis and/or treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist or Licensed Mental Health Clinician (LMHC)

_____ Other(s) please list: _____

➲ This Authorization will expire on (provide date)_____**(authorization can be granted for up to 1 year from the signature date below)** or automatically **expire 30 days from signature date (if an expiration date is not specified).**

PLEASE READ ➲ I understand that federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (e.g., 42 CFR Part 2, HIPAA) protect my privacy and confidentially. I can revoke this Authorization permitting access to my Patient Record(s) at any time in writing as long as OnCall had not already taken action in reliance on it. I recognize that the re-disclosure of any further sharing or exchange of my Patient Record(s) as shown above may occur without my written consent by someone who receives my Patient Record(s) in accordance with this Authorization that may result in a loss of my privacy protection. I know that I have the right to request an accounting of the disclosures of my Patient Records. I understand also that OnCall will not condition my treatment at OnCall on signing this Authorization except as permitted by law. I have read, understand, and agree with this Authorization, and freely authorize the use and disclosure of my Patient Record(s) as shown above.

_____ ➲ Signature

_____ ➲ Print Name

_____ ➲ Date