AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME:_____ **MAIDEN / PRIOR NAME:** _____ **BIRTH DATE:**_____

CONTACT NUMBER: _____ **ADDRESS:**_____

DATES OF SERVICE REQUESTED:_____ *(If left incomplete, most recent date of service will be provided.)*

I AM REQUESTING DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE FOLLOWING PURPOSE(S):

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Employer ☐ Other:_____

I AUTHORIZE THE RELEASE OF THE FOLLOWING TYPE OF RECORD (Initials Required):
I understand that the information in my health record may include information relating to medical, Psychiatric-mental health, drug and/or alcohol use/treatment, and/or communicable disease, Immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

_____ Alcohol / Substance Abuse or Treatment / Referral
_____ Sexually Transmitted Diseases
_____ HIV / AIDS – related treatment

I AUTHORIZE / REQUEST THE RELEASE OF THE FOLLOWING:

☐ Transition of Care Packet – [Discharge Plan Parts I & II, Medication Reconciliation, Discharge Safety Plan, & Advance Directives]
☐ Initial Assessments
☐ History and Physical
☐ Psychiatric Evaluation
☐ Discharge Summary
☐ Progress Notes
☐ Lab / Diagnostic Reports
☐ TB Result
☐ Billing Statement
☐ Other:_____

PLEASE RELEASE MY INFORMATION VIA:
☐ **VERBAL EXCHANGE OF INFORMATION** ☐ **SECURE EMAIL** ☐ **MAIL** ☐ **I WILL PICK-UP** ☐ **FAX (Number:**_____**)**

TO BE RELEASED BY:
☐ **Via Linda Behavioral Hospital**

☐ _____ (____)_____ (____)_____ _____
Name/Agency Telephone Number Fax Number City State Zip Code

TO BE RELEASED TO:
☐ **Via Linda Behavioral Hospital** EMAIL: _____

☐ _____ (____)_____ (____)_____ _____
Name/Agency Telephone Number Fax Number City State Zip Code

I hereby voluntarily authorize the disclosure of information from my medical record. This form must be completed in full before signing below:

_____/_____
PATIENT'S SIGNATURE DATE PARENT / LEGAL GUARDIAN SIGNATURE *(if applicable)* Relationship to Patient

_____/_____
WITNESS SIGNATURE Date / Time Signed PHYSICIAN APPROVAL SIGNATURE *(For Patient / Guardian Requests Only)* Date / Time Signed

This authorization will expire on _____/_____**/2023.** *(If not indicated, authorization will expire sixty (60) days from signature date)*
You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

_____
REVOCATION SIGNATURE DATE / TIME

This authorization is intended to allow Via Linda Behavioral Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.