Harbor Health

Authorization for Release of Patient Information

Type of Release *(select one)*	**Preferred Delivery Method** *(select one)*
☐ Electronic ☐ Paper ☐ CD	☐ Mail ☐ Secure Email ☐ Fax (continuation of care only)

Patient name (Print) _____

Date of birth _____ Medical Record number (if available) _____

Patient's Mailing Address _____

City _____

State _____ ZIP Code _____

Telephone Number: Cell _____ Home _____ Work _____

Email _____

I hereby authorize:	**To release Health Information to:**
Name of Person/Facility/Provider releasing health information	Name of Person/Facility/Provider receiving health information
Street Address	Street Address
City, State, ZIP Code	City, State, ZIP Code
Telephone Number	Telephone Number
Fax Number *(if applicable)*	Fax Number *(if applicable)*

Health Information to be Disclosed

I request the release of the following information (check all that apply). *If all health information is to be released, please only check the first box.*

☐ Entire Medical Record (excluding psychotherapy notes)	☐ Billing Information	☐ Other
☐ Only Medical Records from _____ to _____	☐ Radiology Imaging / Films	

Your initials are required to release the following information

_____	Mental health records (excluding psychotherapy notes)
_____	Substance Use Disorder (SUD) Records *Complete the Part 2 Consent Addendum below if these records are maintained by a program subject to 42 C.F.R. Part 2.*
_____	Genetic information (including genetic test results)
_____	HIV/AIDS, STD/STI or other communicable diseases test results/treatment

Purpose of Release

(Choose only one)

☐ Continuation of Care*	☐ Insurance	☐ School
☐ Personal Use	☐ Legal purposes	☐ Employment
☐ Billing/Claims	☐ Disability determination	☐ Transfer of Medical Care**

☐ Other _____

***Continuity of Care = sharing information to support ongoing treatment**
**** Transfer of Medical Care = care is being moved to a new provider**

What time period should we search for records?

☐ Last 6 months (recommended)

☐ I want to specify a date range from _____ to _____

42 C.F.R. Part 2 Consent Addendum

COMPLETE THIS SECTION ONLY IF YOU ARE AUTHORIZING THE RELEASE OF SUBSTANCE USE DISORDER RECORDS BY A PROGRAM SUBJECT TO 42 C.F.R. PART 2.

I authorize: _____ to disclose the following substance use disorder records about me:
(Name of Part 2 program or other person/entity authorized to disclose)

☐ All substance use disorder treatment records, excluding SUD counseling notes
☐ Only the following specific records: _____

to:

☐ The recipient identified in this authorization form
☐ Other recipient: _____

For the following purpose:

☐ At my request
☐ Continuity of care / treatment
☐ Payment or health care operations
☐ Other: _____

This Part 2 consent expires on: _____or upon the following event: _____.

I understand that I may revoke this consent in writing at any time by sending written notice to Harbor Health Medical Records at medicalrecords@harborhealth.com. Revocation will not affect disclosures already made in reliance on this consent.

I understand that records disclosed to a covered entity or business associate for treatment, payment, or health care operations may be redisclosed in accordance with HIPAA, except that they may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against me without my written consent or as otherwise permitted by 42 C.F.R. Part 2.

I understand that signing this Part 2 consent is voluntary. Refusing to sign will not affect my treatment, payment, enrollment, or eligibility for benefits, except as follows: _____.

Patient Signature: _____ Date: _____

Authorization

- Expiration of Authorization: Unless otherwise revoked, the authorization's expiration date, event, or condition:

  _____

  .

  If no expiration date or condition is indicated, the authorization will expire 12 months after the date of my signing this form.
- I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law.
- I understand that I have a right to revoke this authorization, in writing at any time by sending such written notification to the Health Information Management department at medicalrecords@harborhealth.com or my healthcare provider. However, any use or disclosure that occurred prior to the date consent is revoked will not be affected.
- I understand that signing this authorization to release form is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I understand the disclosed information may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy laws.
- I understand that I may be charged a reasonable cost-based fee as authorized by law for copies of my medical records.
- I understand that I am entitled to a copy of this authorization to release form.

Patient or Legal Representative signature	
Date	
Printed name of Legal Representative *(if applicable)*	
Relationship to patient *(if applicable. Documentation may be required)*	

Minor Authorization (if applicable)

A minor individual's signature is required for the release of certain types of information, including, but not limited to: the release of information related to reproductive care; sexually transmitted diseases; drug, alcohol or substance abuse and mental health treatment.

Patient signature (minor)	
Date	