region ten
community services board

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, or my authorized representative, request that health information regarding my care and treatment be released by Region Ten Community Services Board ("Region Ten") as set forth on this form, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I further authorize Region Ten to use the following health information for the purpose listed below or to disclose the following information to the person/agency listed below:

Patient/Client Name: Date of Birth: Social Security Number:
Address

This health information shall **be disclosed to** or **exchanged with** and used by the following individual or organization:

Full Name:	Address:	

Information to be used or disclosed *[check all that apply]* :

- ☐ Diagnosis
- ☐ Assessments
- ☐ Treatment Plan
- ☐ Medication Record(s)
- ☐ Psychological Evaluation
- ☐ Billing / Insurance Information
- ☐ History & Physical Examination Report
- ☐ Progress Notes
- ☐ Discharge / Transition Summary
- ☐ Summary of performance and attendance
- ☐ Social History
- ☐ Benefits
- ☐ Other:_____

Purpose of use/disclosure:

☐ Assessment ☐ Follow-up Care ☐ On-going Treatment ☐ Other (specify: _____

Dates of service requested:_____

This authorization may include disclosure of information relating to **alcohol**, **drug and other substance abuse information**, **mental health information** and **confidential HIV** (Human Immunodeficiency Virus that causes AIDS) **related information** only if I place my initials as provided, below:

Include: (indicate by initialing)
_____ Alcohol/Drug/Substance Abuse Information
_____ Mental Health Information
_____ HIV-Related Information

As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission for Region Ten Community Services to release or to obtain and use confidential health information. No threat or other coercive measures have induced me to sign this form. I may refuse to sign this authorization. If I do refuse to sign, treatment, payment, enrollment or eligibility for benefits will not be affected. I also understand that the information disclosed may be subject to redisclosure by the recipient and may no longer be protected by state or federal law. I understand and consent to the use of a facsimile of this form as equivalent to the original.

I understand that I may revoke this Authorization at any time, but not retroactive to information already released in accordance with the authorization. I will notify Region Ten Community Services in writing of my desire to revoke this Authorization; my revocation is not effective until delivered in writing to the person in possession of the medical records.

Unless otherwise revoked, this Authorization will expire one (1) year from the date specified. or, on the date, event or condition described as:_____

Signature:	Date:
Parent, Guardian, Representative Signature:	Date:
Basis of Representative's authority to sign Authorization:	

Note: This information may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. These Federal Regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse individual.