**Authorization for use and/or disclosure of Protected Health Information.**

Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_

Specific Date(s) of Service\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_ or All record date(s) available:\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize SMITH FAMILY HEALTHCARE, LLP to

release to\_\_\_\_\_ request from\_\_\_\_ exchange with\_\_\_\_\_\_, my protected health information as specified below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street, City, State and ZIP) Fax Number

PATIENT INFORMATION IS NEEDED FOR:

\_\_Continuing Medical Care \_\_ Military \_\_ Social Security/Disability \_\_ Insurance \_\_Personal Use \_Legal Purpose \_\_School \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFORMATION TO BE RELEASED OR ACCESSED:

\_\_History & Physical \_\_Consultation \_\_ Report \_\_Emergency Room Record \_\_Operative Reports \_\_Discharge/Death Summary Face Sheet \_\_ Lab/Path Reports \_\_X-Ray Reports/Images \_\_ Progress Notes \_\_ Psychiatric Evaluations \_\_Alcohol and Other Drug Treatment Services \_\_\_\_Physician Orders

\_\_ All Medical Records \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time. I understand that treatment services, payment or eligibility are not contingent upon my decision concerning signing of this authorization.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legally Authorized Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient or Legally Authorized Representative­­­ Relationship to Patient

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see 42 CFR 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 42 CFR 2.65."

Date Revoked:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client or Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_