Date request fulfilled: ___/___/_____Total pages released: _____
Request completed by: _____

AUTHORIZATION AND CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize Oceans Behavioral Hospital of _____ to use and disclose my health information to the recipient below. Dates of Service_____

Patient information

Full Name: _____ Date of Birth: ____/____/_____ SS#: XXX-XX-_____

Mailing Address: _____

Email Address: _____ Phone Number (_____) _____ - _____

Information to be Disclosed to: _____

Mailing Address: _____

Phone Number (_____) _____ - _____ Fax Number: (_____) _____ - _____

Method of Disclosure: ____ Mail ____Patient Pick Up ____Fax ____Encrypted Email __ Unencrypted Email

***NOTE**: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.*

Purpose(es) of Disclosure: _____

Protected Health Information to be released:

- ☐ History and Physical examination reports
- ☐ Consultations
- ☐ Laboratory and X-ray Reports
- ☐ Discharge Summary
- ☐ Physician Progress Notes
- ☐ Physicians' Orders
- ☐ Treatment Plans
- ☐ Psychiatric Evaluation
- ☐ Psychosocial Assessment
- ☐ Diagnosis
- ☐ Exclude HIV, AIDS, STD Test Results
- ☐ Entire Medical Record
- ☐ Other (please explain): _____

_____(***initial***) I hereby consent to the disclosure of substance use disorder information

I understand that, if I have any records containing substance use disorder information, such records are protected by federal law and will not be included unless I specifically consent. I understand that substance use disorder information may be contained throughout my records and that my voluntary consent is needed to fully release the categories I marked above. I understand that, without my consent, federal regulations may prevent the release of any PHI despite my directions above.

-I understand that I may inspect or copy the protected health information described by this authorization.
-I understand that this authorization may be revoked in a writing delivered to the Health Information Management Department of Oceans Behavioral Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed (see Notice of PrivacyPractices).
-I understand that some information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
-I understand that Oceans Behavioral Hospital shall not condition treatment on my providing authorization for the requested use or disclosure and that I have the right to refuse to sign thisauthorization.
-I understand and agree that this authorization is voluntary, that the information to be disclosed is protected by law, and that the use/disclosure identified above is to be made to conform to my directions.
-I understand the information in my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease

Expiration Date: This authorization will expire on (date or event) _____

(*If left blank, this Authorization will expire 6 months from date it is signed.)*

Signatures. I have read this Authorization and Consent, and I confirm that it is consistent with my directions. I understand that by signing this form, I am consenting to and authorizing the use and/or disclosure of my confidential protected health information.

_____ _____ _____
Patient Signature or Legal Representative (please provide supporting documentation.) Date *Relationship to patient*

☐ Verbal Authorization obtained by: _____
In the event of a verbal order, this should be used only after all attempts to obtain a written consent have been exhausted, please verify the patient's identity with 2 witnesses.

_____ _____ _____ _____
Witness #1 (Print and Sign) Date *Witness #2 (Print and Sign)* Date

Date Authorization was Revoked (if applicable): Date: _____Time: _____