Authorization For Use and Disclosure of Protected Health Information Form

Name of Client: _____ Date of Birth:_____ Client ID #: _____
mm-dd-yyyy

I authorize **Clarvida** to disclose and/or receive information involving the above-named individual from and/or to:

Name of Individual or Group: _____ **Agency/Relationship: (contact information)** _____

Purpose for releasing/disclosing information (described as specific as possible):

☐ Coordination of Care ☐ Workers Comp ☐ Disability Determination ☐ Personal

☐ Insurance Claim ☐ Legal ☐ Other: _____

Additional information regarding purpose: _____

☐ Information for Clarvida to **Disclose to** the above entity		☐ Information for Clarvida to Receive from the above entity
☐	Dates of participation	☐ Dates of participation
☐	Assessments	☐ Assessments
☐	Diagnostic Evaluations	☐ Diagnostic Evaluations
☐	Psychological Evaluations	☐ Psychological Evaluations
☐	Treatment Plans/Service Plans	☐ Treatment Plans/Service Plans
☐	Crisis Plans	☐ Crisis Plans
☐	Progress Notes/Reports	☐ Progress Notes/Reports
☐	Discharge Summary	☐ Discharge Summary
☐	Medical Reports	☐ Medical Reports
☐	Medications	☐ Medications
☐	Lab Results	☐ Lab Results
☐	Educational Records	☐ Educational Records
☐	Guardianship documents	☐ Guardianship documents
☐	Written and Verbal Communications	☐ Written and Verbal Communications
☐	Other: _____	☐ Other: _____
☐	Other: _____	☐ Other: _____

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Additional information regarding disclosures or restrictions of communication:

This consent expires on: _____
(describe date, event, or condition upon which consent will expire, not to exceed one year from date of signature, if applicable)

This form implements the requirements for consumer authorization to use, disclose and exchange health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R part 2), and state confidentiality laws governing medical, mental health, developmental disabilities, and substance abuse services.

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy laws (45 C.F.R. Part 164 or 42 C.F.R. Part 2) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When Clarvida discloses mental and behavioral health or developmental disabilities information protected by state law or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), the recipient of the information is informed that redisclosure is allowed or prohibited according to these two laws.

Education Records: Documents (including some treatment documents) that are deemed as education records are protected under FERPA (Family Educational Rights and Privacy Act; 34 CFR Part 99) and state confidentiality laws. Information identified as education records will be disclosed according to those regulations.

I authorize the use/disclosure/exchange of information in my medical record relating to mental health diagnosis and treatment.
_____ *(initials)*

I authorize the use/disclosure/exchange of information in my medical record relating to my substance use disorder and treatment (for substance abuse programs protected under 42 CFR Part 2).
_____ *(initials)*

I authorize the use/disclosure/exchange of information in my medical record relating to acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV): You may receive more complete care if you release this information, but you could experience discrimination if it is misused.
_____ *(initials)*

I authorize the use/disclosure/exchange of information in my medical record relating to genetic information.
_____ *(initials)*

I authorize the use/disclosure/exchange of information in my medical record related to my reproductive healthcare.
_____ *(initials)*

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I understand I may review my records upon request at any reasonable time including prior to the authorized release of such records.

I understand that refusal to consent to the release of all or some of my health care information may not be a condition to obtain treatment, unless otherwise permitted by state law. However, refusal could result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences. I will not be denied services if I refuse to consent to a disclosure for other purposes.

In the event there is conflict between any provision in this form and any applicable law, the law will take precedence.

Revoking Authorization: I understand I have the right to revoke (or cancel) this authorization at any time. If I revoke this authorization, I must do so in writing by completing and signing a Revocation of Authorization Form which can be obtained from and returned to my provider or State Privacy Officer at your local Clarvida office. I understand my revocation could be the basis for denial of health benefits or other insurance coverage or benefits. I understand the revocation will not apply to information that has already been released in response to this authorization.

For substance abuse treatment records covered under 42 CFR Part 2, the regulation prohibits unauthorized use or disclosure of these records.

The following applies:

- I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- I understand that if the recipient of my substance use disorder records is covered under the consent I provided for use/disclosure of records for treatment, payment, or healthcare operations, the information authorized in this consent may be redisclosed for those purposes in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.
- I understand that I could be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law.

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For Parents/Guardians of Minors: If the minor has consented to care, Clarvida cannot disclose any of the minor's health care information unless the minor consents to the release. If the minor may not consent to care, any consent for disclosure to others must be signed by the parent/guardian/legal representative.

Dated: _____

_____
Signature of Client

_____
Name of parent/guardian/legal representative

_____
Signature of parent/guardian/legal representative *

_____
Witness Signature/Relationship

*Describe authority to sign on behalf of the Client _____

A copy of this form is as valid as the original to allow disclosure of my records and I may request a copy at any time. For substance abuse treatment programs, this form must accompany any disclosure of substance abuse information according to the consent indicated on this form.