

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (HIPAA)

## Serenity Hill Health Care

*(Behavioral & Psychiatric Services)*

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### 1. Patient Information

- **Patient Full Name:** \_\_\_\_\_
  - **Date of Birth:** \_\_\_\_\_
  - **Phone Number:** \_\_\_\_\_
  - **Email (optional):** \_\_\_\_\_
  - **Address:** \_\_\_\_\_
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### 2. Health Care Provider Releasing Information

- **Provider / Facility Name:** \_\_\_\_\_
  - **Address:** \_\_\_\_\_
  - **Phone:** \_\_\_\_\_
  - **Fax:** \_\_\_\_\_
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### 3. Person / Organization Receiving Information

- **Name / Facility:** \_\_\_\_\_
  - **Address:** \_\_\_\_\_
  - **Phone:** \_\_\_\_\_
  - **Fax / Email:** \_\_\_\_\_
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## 4. Information to Be Released

*(Check all that apply)*

- Psychiatric evaluation / assessment
  - Progress notes / clinical notes
  - Therapy notes (excluding psychotherapy notes unless specifically required)
  - Medication and prescription records
  - Treatment plan
  - Discharge / summary of care
  - Appointment history
  - Billing / insurance information
  - Lab or diagnostic results
  - Other (specify): \_\_\_\_\_
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## 5. Purpose of Disclosure

- Continuity of care / treatment
  - Referral or consultation
  - Insurance / billing
  - Legal / administrative
  - Personal use
  - Other (specify): \_\_\_\_\_
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## 6. Sensitive Information Authorization

I specifically authorize the release of the following information (check all that apply):

- Mental health records
- Alcohol and/or substance use disorder treatment records (42 CFR Part 2)
- HIV/AIDS-related information
- Genetic testing information

*If not checked, this information will not be released.*

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## 7. Method of Disclosure

- Secure email
  - Fax
  - Mail
  - Electronic Health Record (EHR) exchange
  - In-person pickup
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## 8. Expiration of Authorization

This authorization will expire:

- On the following date: \_\_\_\_\_
  - One (1) year from the date of signature
  - Upon completion of the following purpose: \_\_\_\_\_
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## 9. Patient Rights & Acknowledgment

- I understand that I may revoke this authorization at any time by submitting a written request, except to the extent that action has already been taken.
  - I understand that information disclosed under this authorization may be subject to re-disclosure and may no longer be protected by HIPAA.
  - I understand that signing this authorization is voluntary and that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this form, except as permitted by law.
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## 10. Signature

- **Patient / Legal Representative Name (print):** \_\_\_\_\_
  - **Relationship to Patient (if applicable):** \_\_\_\_\_
  - **Signature:** \_\_\_\_\_
  - **Date:** \_\_\_\_\_
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## 11. Witness (if required)

- **Witness Name:** \_\_\_\_\_
  - **Signature:** \_\_\_\_\_
  - **Date:** \_\_\_\_\_
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### For Office Use Only

Date Received: \_\_\_\_\_

Processed By: \_\_\_\_\_

Date Released: \_\_\_\_\_