Authorization to Release Protected Health and/or Substance Use Disorder Records

Authorization to Release Protected Health Information Of:		
Patient Name:	Date of Birth:	Phone Number:
Address:		
Authorization to Release Protected Health Information From:		
Facility Name/ Provider: Breen Family Medicine, PLLC	Phone Number: 801-899-7830	Address: FAX: 216-279-8556
Authorization to Release Protected Health Information To:		
Agency/Individual (include contact person):	Relationship to Patient:	Phone Number:
Address:		
Purpose of Disclosure:		
Dates of Treatment/Service Requested (mm/dd/yy --mm/dd/yy):		

Delivery Information:

☐ In Person ☐ Mail ☐ Oral/two- communication ☐ Secure Email
☐ Fax number: ☐ Other electronic format(check with provider for available electronic options):

Release the Following Information (check all that apply):

Patient Health Information:

☐ History and Physical ☐ Emergency Room Records ☐ Treatment Plan ☐ Consultation
☐ Radiology Reports ☐ Laboratory Reports ☐ Operative Reports ☐ Pathology Reports
☐ Discharge Summary ☐ Progress Report ☐ Immunizations ☐ Outpatient Clinic Records
☐ Medication List ☐ Genetic Testing ☐ HIV/AIDS or other communicable disease
☐ Other_____

Mental/Behavioral Health Information:

☐ Evaluation/Assessment ☐ Treatment Plan ☐ Progress Notes ☐ Therapy Records ☐ Discharge Summary
☐ Medication List ☐ Consultation ☐ Other_____

Substance Use Information:

☐ Evaluation/Assessment ☐ Treatment Plan ☐ Consultation ☐ Progress Notes ☐ Therapy Records ☐ Discharge Summary
☐ Drug Test Results ☐ Medication List ☐ Other_____

Financial:

☐ Health Insurance Claim Form ☐ Billing Form ☐ Itemized Billing ☐ Other_____

Authorization Will Remain in Effect for:

☐ 1 year from date signed ☐ one time disclosure ☐ other(date/event/condition):

I understand that:

- I understand that the information to be released may include reference to sensitive information related to drug or alcohol abuse treatment which may be federally protected Under 42 CFR Part 2, genetic testing, HIV/AIDS or other communicable disease and/or mental/behavioral health. By checking the boxes related to this information this disclosure will reveal my presence as a patient at this treatment facility and/or that I am receiving this type of treatment.
- Once this facility/provider discloses my health information by my request, it cannot guarantee the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by federal and state law governing the use and disclosure of my health information.
- The facility/provider will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
- I may inspect, request, or copy any information used or disclosed under this authorization. If I have questions about disclosures of my health information, I can contact the facility/provider and speak to their medical records department.
- This authorization is subject to revocation at any time except to the extent that the facility/provider or other lawful holder of the protected health information has already acted in reliance of this authorization. The revocation must be provided in writing to the "facility."

Signature of Patient or Representative	Date:
Printed Name of Representative:	Relationship to Patient: