# Human Supports of Idaho

**Boise Clinic:** 4477 W Emerald St., Suite C100, Boise, ID 83706
Phone: 208-321-0160 | Fax: 208-321-0221

**Caldwell Clinic:** 206 E. Elm St., Caldwell ID 83605
Phone: 208-454-8389 | Fax: 208-454-8404

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

| | | | |
|---|---|---|---|
| **Participant Legal Name:** | | **Date of Birth:** | |
| **I Authorize:** | **Human Supports of Idaho** | | |
| **To Exchange Information With (Request and/or Disclose):** | **Facility:** _____<br>**AND/ OR**<br>**Provider/ Person:** _____<br>**Contact Information:** _____ | | |
| **Purpose for Disclosure:** | ☐ Coordination of Care<br>☐ Continuation of Care<br>☐ Disability | ☐ Insurance<br>☐ Legal<br>☐ School | ☐ Personal<br>☐ Research<br>☐ Other (specify): |
| **Regarding Records:** | From: _____ To: _____<br>MM/DD/YYYY MM/DD/YYYY | Expiration Date of ROI: _____<br>MM/DD/YYYY<br>**If no date is entered this ROI will expire 12 months from date of signature.* | |
| **Specific Information to be Released:** | ☐ Developmental Disabilities Services<br>☐ HIV/AIDS Related Information<br>☐ Medical Services<br>☐ Medication Records<br>☐ Mental Health (other than psychotherapy notes or substance/alcohol services)<br>☐ Substance/Alcohol Use Disorder Services (other than psychotherapy notes)<br>☐ Other (specify): | ☐ Psychotherapy Progress Notes (***by checking this box, I am waiving any psychotherapist-patient privilege***)<br>☐ Sexually Transmitted Diseases<br>☐ Comprehensive Diagnostic Assessments and Psychiatric Evaluations (not including the GAIN)<br>☐ Substance Use Disorder Specific Assessment and Screening Tools (ASAM, GAIN, DUI Evaluation) | |
| **Authorized Disclosure Format(s):** | ☐ CD/Flash Drive (secure format)<br>☐ E-mail (encrypted format)<br>☐ E-mail (**NOT** encrypted format, i.e. Gmail, Yahoo...etc.)<br>☐ Other (specify): | ☐ Fax<br>☐ Hand Delivered (paper format)<br>☐ US Mail (paper format)<br>☐ Verbal Communication<br>☐ Web Portal | |

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent any time by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 12 months after the signature date, and/or if services have not been rendered for the last year. I also understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that this agency may not condition treatment, payment, enrollment, or eligibility for benefits whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization.

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|---|---|
| **Participant Signature:** | **Date:** |
| **Guardian Signature:**<br>**(Relationship to participant)** | **Date:** |
| **Employee Signature:** | **Date:** |