White Cloud Health Center, LLC

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby voluntarily authorize the disclosure of information from my record, as identified below:	
Patient Name:	**Date of Birth:**
Check applicable status: ☐ Adult ☐ Emancipated Minor ☐ Minor	

INFORMATION IS TO BE RELEASED BY:	**AND IS TO BE PROVIDED TO:**
Name of Facility/Organization/Person:	Name of Facility/Organization/Person:
Mailing Address:	Mailing Address:
City/State/Zip:	City/State/Zip:
Phone #:	Phone #:
Fax #:	Fax #:

The purpose or need for this disclosure is:

☐ Further Treatment/Care	☐School	☐ Disability	☐ Verbal Discussion of Care
☐ Personal Use	☐ Insurance	☐ Civil, criminal, administrative, or legislative proceedings	☐ Other (specify):_____

Type of information to be released (check appropriate box(es)):

☐ Most recent two-year history	☐ Medications list
☐ Only health information related to (specify):	☐ Lab results (specify):
☐ Only health info. for this time frame (specify dates):	☐ Imaging results (specify):
☐ Entire health record	☐ All immunization records
☐ Other (specify):	

Sensitive information: **Initial** on the line if you authorize any of the following sensitive information disclosed:

____ Sexually transmitted diseases ____ All Substance Use Disorder Treatment Information _____ Genetic testing information

____ HIV/AIDS related information ____ Psychotherapy Notes/SUD Counseling Notes (may not be combined with other info.)

____ Other (specify): _____

I understand my records are protected and cannot be disclosed without my written consent unless otherwise provided under applicable law. I understand that my records may be redisclosed in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, 45 C.F.R. Parts 160 and 164 except for uses and disclosures for civil, criminal, administrative, and legal proceedings against me. I may revoke this consent at any time except to the extent an action has been taken in reliance on it before my revocation was received. If this consent has not been revoked, it will **expire one year from the date of my signature**, unless I specify a shorter expiration date or event here (specify):_____. I understand that no one may condition treatment or eligibility for care on my providing consent, except if such care is research related or provided solely for the purpose of creating protected health information for disclosure to a third party, or as otherwise allowed or required by law. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with a right to contest a claim under the policy. I understand that if the person/entity authorized to receive this information is not a health plan or health care provider, the information *may* no longer be protected by law. Each disclosure of substance use disorder treatment records made under this authorization, as applicable, shall require a statement explaining that 42 C.F.R. Part 2 prohibits unauthorized re-disclosure of the records.

Signature of Patient:	Date:
Personal Representative (State relationship to patient) or Witness (if signature is a thumbprint or mark):	Date:

THIS SECTION FOR OFFICE USE ONLY	APPROVED BY:	COMPLETED BY:
PATIENT RECORD #	DATE APPROVED:	DATE COMPLETED: