ROSEMAN MEDICAL GROUP
ROSEMAN UNIVERSITY OF HEALTH SCIENCES

CONSENT/AUTHORIZATION TO RELEASE/EXCHANGE PROTECTED HEALTH INFORMATION (PHI) AND CONFIDENTIAL SUBSTANCE USE DISORDER (SUD) PATIENT RECORDS

_____ Date of Birth: _____
Print Name of Client

_____ Phone Number: _____
Print Name of Parent/Guardian providing authorization (if applicable)

Address: _____
Street City State Zip Code

I understand this release is voluntary and applies to all programs and services operated under the auspices of EMPOWERED at Roseman University College of Medicine. I understand that my protected health information (PHI) may be protected by the federal rules for privacy under the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PHI may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted.

I understand that my alcohol and/or drug treatment records are protected under Federal regulations governing confidentiality and drug abuse patient records, 42 CFR, Part 2 and HIPAA, and cannot be disclosed without my written consent unless otherwise provided by the regulations.

I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. I understand that I may revoke this authorization at any time by notifying EMPOWERED in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.

I hereby authorize EMPOWERED to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

I hereby authorize EMPOWERED to exchange/release/obtain information:

☐ Verbally only ☐ In written form only ☐ Both verbally and in writing

Organization or Individual receiving/communicating the information:

_____ _____
Name of Organization/Individual Email address

_____ _____
Address City, State Zip Code Phone

Release the following PHI to the party listed above:

☐ ENTIRE RECORD – OR:

☐ Appointments	☐ Laboratory Results	☐ Billing Records
☐ Attendance	☐ Medications/Dosing	☐ History and Physical
☐ Assessments	☐ Discharge Summary	☐ Other _____
☐ Progress Notes	☐ Diagnoses	

Due to the sensitivity of the following information, please check off and initial if you would like the following information to be released:

☐ Notes and reports related to STDs, including HIV/AIDS ____ Initial
☐ Psychiatry/Mental Health Notes ____ Initial
☐ Notes related to Drug/Alcohol Use ____ Initial

Duration of release (check one):

☐ This release will remain in effect for one (1) year, unless otherwise stipulated or revoked in writing.

☐ From _____ (MM/DD/YYYY) To_____(MM/DD/YYYY)

The purpose of this release is:

_____

_____

Signature of Client or Parent/Guardian Date

_____ _____