EVOLVE

RESTORATIVE CENTER

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient Information

Patient Legal Name: _____

Date of Birth (MM/DD/YYYY): _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____

Clinic / Hospital Health Provider

Who is providing the protected health information (PHI)?

Name: _____

Mailing Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____

Receiving Person / Organization

Who is receiving the protected health information (PHI)?

Name: _____

Mailing Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____

Dates of Service for Request

From Date (MM/DD/YYYY): _____ To Date (MM/DD/YYYY): _____

Protected Health Information (PHI) to Be Released

Check the box(es) for information you are authorizing for release:

☐ All health information pertaining to my history and physical, discharge report, consults, operative report, lab/radiology test results

☐ Only the following records or types of health information (please check all that apply):

☐ Labs ☐ Radiology Reports ☐ Medical Images ☐ Physical Therapy

☐ Clinic Office Visit ☐ Billing Statements

I specifically authorize release of the following information (check as appropriate):

☐ Mental health diagnosis or treatment information _____ (initial)
(Welfare and Institutions Code sections 5328, et seq.)

☐ Genetic testing information _____ (initial)
(Health and Safety Code section 124980(j))

☐ HIV/AIDS test results _____ (initial)
(Health and Safety Code section 120980(g))

☐ The following substance use disorder treatment information:

_____

_____

_____ _____ (initial)
(42 C.F.R. Part 2)

Release Delivery Method

☐ In Person ☐ Mail ☐ Secure email* ☐ Fax

*Please initial here: _____ to indicate you understand the security risk involved that once the information leaves Evolve Restorative Center's secure mode of transmission, the communication may be read/intercepted by a third party.

Purpose for this Release

How is the PHI to be used?

- Patient/Patient representative request
- Continuing care/Treatment
- Legal
- Other/Description: _____
  This information will not be used for any purpose other than its intended use.

Patient Rights

By signing this authorization, I understand:

- I authorize the use or disclosure of my Protected Health Information (PHI) as described for the purpose(s) and to the persons listed.
- I may refuse to sign this authorization, and refusal to sign will not affect my treatment, payment, or my eligibility for benefits except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party. I understand that medical treatment is not conditioned on my release of Protected Health Information to any third party.
- I have the right to receive a copy of this authorization.
- I can identify a date of expiration of this authorization or an event. If I do not

request a specific expiration date or event, this authorization will expire in 12 months.

- I have the right to revoke this authorization in writing signed by me or my legal representative and submitted to the following address:

  Evolve Restorative Center
  220 Concourse Blvd.
  Santa Rosa, CA 95403

  My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. Revocation will not affect uses/disclosures that have already occurred. (For my substance use disorder treatment information, I have the right to revoke this information verbally).
- I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosures is obtained from me or unless such disclosure is specifically required or permitted by law.

Expiration of Authorization

Unless otherwise revoked or a date or event of expiration is identified below, this authorization expires twelve months from the date of signing this form.

Expires (MM/DD/YYYY)/Event: _____

Patient Signature

_____ _____

Print Name (patient/legal representative) Signature (patient/legal representative)

_____

Date Time AM/PM

Your signature authorizes the release of information to the same person(s) as designated, for treatment provided after the date of this signature, as long as such treatment occurs before the expiration date.

Legal Authority (Relationship to patient if signed by a person other than the patient)

What legal authority do you have to authorize the release of PHI?

☐ Patient ☐ Parent of Minor ☐ Guardian
☐ Conservator ☐ Power of Attorney ☐ Executor of Will
☐ Administrator of Estate ☐ Other: _____

OFFICE USE ONLY

Date revoked: _____ **Staff initials: _____**