

Authorization for Disclosure of Protected Health Information

General

Client Name: _____ Date of Birth: _____
 Client Address: _____ City/State/Zip: _____
 Phone: (_____) _____ May we leave a message? (check one) Yes No

The undersigned hereby authorizes and requests the release of confidential health information: (PLEASE CHECK)

to the agency and individual listed below
 from the agency and individual listed below

for review, examination and/or photocopies between **Porter-Starke Services, Inc.**, 601 Wall St., Valparaiso, IN 46383 and

<i>Name of Person or Agency Receiving Records</i>	<i>Street Address</i>
_____	_____
<i>City, State, Zip Code</i>	(_____) _____ (_____) _____
	<i>Phone Number</i> <i>Fax Number</i>

Access to this information is limited as designated below:

Release from the Time Period of: (check one) **1) Any Admissions** **2) Only Specified year(s):** _____ *specify year(s)*

Release ONLY THOSE PORTIONS CHECKED BELOW of the Medical Record:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Assessment/Evaluation/Progress Note | <input type="checkbox"/> Lab/Drug Results | <input type="checkbox"/> Medications | <input type="checkbox"/> Psychological Testing Results |
| <input type="checkbox"/> Appointments/History | <input type="checkbox"/> Financial/Insurance | <input type="checkbox"/> IOP Forms | |
| <input type="checkbox"/> Verbal Communication | <input type="checkbox"/> Letter | <input type="checkbox"/> Form (specify type): _____ | |

Purpose of Release: (check one) Continuity of Care
 Emergency Contact Only: I understand by checking this box, if nothing else is designated, Porter-Starke Services will only use in case of an emergency and only disclose details of the emergency.
 Other (specify): _____

Date Records Needed: _____ (A fee may be required if records are needed less than 48 hours.)

Please check one: I will **pick up** the records.
 Mail records to the above address.
 Email* records to this email: _____
**I understand that email can be insecure. I am accepting the risk by allowing you to email my medical records to the email listed.*

I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that records not protected by Federal confidentiality rules (42CFR Part 2) may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I cannot be required to sign this authorization as a condition for having treatment provided or obtaining payment for the same.

Date, event or condition this authorization expires: _____. If no date, event or condition is specified, this authorization expires 60 days after services have been terminated or when all financial responsibilities have been satisfied. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation or oral request to the Health Information Department.

This information may be disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Client Signature: _____ **Date:** _____

Relationship to Client (if signed by responsible party): _____ **Request Received by:** _____

FOR OFFICE USE ONLY

Client Name: _____ **Client MRN:** _____

- Scanning Only Request Info from Another Provider Send Out Medical Records - ROI Attached Sent Out Medical Records - ROI Is Already on File
 Info Given to Client, ROI Attached, Please Scan