PORTER STARKE SERVICES
Health • Balance • Hope

Authorization for Disclosure of Protected Health Information
Primary Care Physician

Client Name: _____ Date of Birth: _____

Client Address: _____ City/State/Zip: _____

Phone: (_____) _____ May we leave a message? (check one) ❑ Yes ❑ No

❑ **I need help obtaining a Primary Care Physician (PCP).** _____ *Initial here to confirm you have received a PCP referral list.*

❑ **I do not have a Primary Care Physician (PCP) and decline assistance.**

❑ **I have a Primary Care Physician (PCP).** If you selected this option, please complete:

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**

_____ _____
Primary Care Physician/Clinic ***Street Address***

_____ (_____)_____ (_____)_____
City, State, Zip Code ***Phone Number*** ***Fax Number***

The documents listed below may be released for the purpose of Continuity of Care:

☒ Assessment/Evaluation ☒ Progress Notes ☒ Psychological Testing ☒ Lab/Drug Results
☒ Medications ☒ Appointments/History ☒ Verbal Communication

☐ **Mail or fax records to the above address.**

☐ **Email* records to this email:** _____.

I understand that email can be unsecure. 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:** _____