# AUTHORIZATION FOR THE USE, EXCHANGE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

| **Participant Name:** | **Participant Date of Birth:** |
|---|---|
| **Participant Phone Number:** | **Participant Email:** |

Completion of this document ("**Authorization**") authorizes the use and/or disclosure of your protected health information as specified below. **Failure to provide all information requested may invalidate this Authorization.**

I hereby authorize _____
***(HeathRIGHT 360 Program Name)***

to use and disclose the following individually identifiable health information of mine, including **substance use disorder information** (check as appropriate) for the date range of (month/year)_____ to present **or** month/year_____.

☐ All medical or mental health records included in my record

***OR***

☐ Only the following types of protected health information:

**If you are a client receiving or has received services from one or more of HR360s Behavioral Health or Mental Health Programs, please indicate the items below you authorize us to share:**

☐ Substance Use Disorder Information
☐ Substance Use Disorder Treatment Plan
☐ UA Results
☐ Diagnoses
☐ Physical Exam Results
☐ Current Medications
☐ Progress Notes/ Summary
☐ Emergency Contact Info
☐ Mental Health Treatment Plan
☐ Mental Health Summary
from (date)_____ to (date)_____
☐ Discharge Summary/ Information
☐ HIV/AIDS Information
☐ Verification of Program Participation
☐ Intake/Assessment Summary

**If you are a patient receiving or who has received services from an HR360 medical and/or dental clinic, please indicate the items below you authorize us to share:**

☐ Substance Use Disorder Information
☐ Substance Use Disorder Treatment Plan
☐ UA Results
☐ Diagnoses
☐ Physical Exam Results
☐ Mental Health Treatment Plan
☐ Mental Health Summary
from (date)_____ to (date)_____
☐ Discharge Summary/ Information
☐ HIV/AIDS Information
☐ Billing Records

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- ☐ Current Medications
- ☐ Progress Notes/ Summary
- ☐ Emergency Contact Info
- ☐ Labs
- ☐ Diagnostic Images
- ☐ Dental (sub-categories:visits or x-rays)

## Release requested information to the following individual(s) or entity(ies):

*(Please specify name(s) of individual or organization, mailing address and/or e-mail address, as applicable )*

| **Name of Receiving Individual/Organization** | **Physical Mailing Address** *(if requesting info be sent my mail)* | **E-mail Address** *(if requesting info be sent electronically)* | **Phone and/or Fax #** *(if requesting info be faxed)* |
|---|---|---|---|
| | | | Ph:<br><br>Fax: |
| | | | Ph:<br><br>Fax: |
| | | | Ph:<br><br>Fax: |

## For the specific purpose(s) of *(please be as specific as possible):*

_____

_____

## My Rights

I understand that my health records used and/or disclosed pursuant to this Authorization may be subject to redisclosure by the recipients. Such redisclosure is in some cases not prohibited by state law and may no longer be protected by federal law. California law prohibits the recipient of my protected health information from making further disclosures unless the recipient obtains another authorization from me or unless such disclosure of protected health information is required/permitted by law. My substance use disorder information may not be re-disclosed unless another authorization for such disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law.

I further understand that:

- I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it. The revocation must be made in writing, signed by me

or on my behalf, and delivered to HealthRIGHT 360 at 1563 Mission Street, San Francisco, CA 94103.

- I am entitled to a copy of this Authorization.
- I may refuse to sign this Authorization, and my treatment, payment, enrollment, or eligibility for benefits will not be affected if I do not sign this Authorization.
- I may inspect or obtain a copy of the protected health information that I am being asked to allow the use or disclosure of subject to this Authorization.

Unless I revoke my Authorization earlier, I understand that this Authorization will remain in effect until the date provided below:

_____

***(Date Authorization expires, if left blank authorization expires one year from date of signature)***

I have had an opportunity to review and understand the content of this Authorization. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____

*(Participant Name & Signature)* *(Date)*

Or signed by and Authorized Representative on behalf of Participant:

_____ _____

*(Authorized Representative Name & Signature)* *(Date)*

Describe Authorized Representative's Relationship to Participant:

_____

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**NOTICE REGARDING THE RELEASE OF CONFIDENTIAL SUBSTANCE USE DISORDER INFORMATION**

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.