



Protected Health Information (PHI) Release Authorization

Name (First, MI, Last) _____ DOB ____ - ____ - ____

I hereby authorize disclosure of my Protected Health information as follows:

Release FROM: GSPA/GSSC or Specify:	
Facility & Person: _____	
Address: _____	

Phone: _____	Fax: _____

Release TO GSPA/GSSC or Specify:	
Facility & Person: _____	
Address: _____	

Phone: _____	Fax: _____

Specify REASON for Release: ___ Transfer of Care ___ Ongoing Care/Specialist ___ Legal ___ Personal
 ___ Billing/Insurance ___ Other: _____

Specify DATES to be released: Mark or describe **Unlimited** _____ (First visit through expiration of this release)
Limited From _____ to _____ **Limited** From _____ to: Ongoing to expiration of this release

Specify for VERBAL topics to be released/discussed: Mark or describe

- Medical information**, including, but not limited to: my symptoms, diagnosis, medications and treatment plan. May include information related to STDs, HIV/AIDS, pregnancy, prenatal care, birth control, family planning, abortion, drug/alcohol/substance abuse, mental/psychiatric care.
- Behavioral health information**, including, but not limited to: my symptoms, diagnosis, medications and treatment plan
- Labs, X-Ray, Drug/Alcohol Screening and other test results
- Billing and Payment Information (including, but not limited to: balances, insurance & bills)
- Appointments: including, but not limited to: schedule, verify, cancel, etc
- Other (be specific) _____

Specify RECORDS to be released: Mark or describe

Specify Items (may include information related to Mental Health, Drug/Alcohol, Genetic Testing, HIV/AIDS, & External Records)

- ___ Office Visit Notes (may include Mental Health, Drug/Alcohol, Genetic Testing, HIV/AIDS, & External Records)
- ___ Procedure/Surgery Notes ___ Lab Results ___ Imaging Reports ___ Alcohol/Drug/Substance Abuse
- ___ HIV/AIDS ___ Genetic Testing ___ Mental Health ___ Medications/Pharmacy ___ Billing Reports
- ___ Entire medical record (includes Mental Health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, & External Records)
- ___ Other: _____

I, the Patient, OR Authorized Person of Patient, UNDERSTAND:

- This release will expire 12 months after date of signature unless date is specified: _____
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I may choose to refuse to sign this form.
- I have the right to inspect or copy the information I am consenting to release within the organization's established policies.
- My right to healthcare treatment is not conditioned on this authorization.
- I understand that disclosure of this information carries with it the potential for re-disclosure and the information may not be protected by federal/state confidentiality rules.
- There may be a charge for the requested records.
- Unless otherwise specified, release may be in any reasonable manner including: paper, unencrypted fax/electronic.

PATIENT/Authorized Person SIGNATURE: _____ **Date:** _____

Authorized Person NAME (print): _____ **Relationship:** _____

For Substance Abuse Disorder Program treatment information (covered by 42 CFR Part 2): Notice to recipient of protected information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (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.