



# AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

The undersigned patient authorizes EASTSIDE ADDICTION PROFESSIONALS to disclose/receive copies of the specified records as he/she has directed.

1. **RECORDS:** The following records are included in this request: (Requires Patient Initials)

\_\_\_\_\_ Identity, dates of attendance, diagnosis, prognosis, recommendations, treatment rendered, assessment, locations, progress, treatment status, dialogue with recipient, treatment summary and treatment coordination.

\_\_\_\_\_ Other: (specify) \_\_\_\_\_

2. **DISCLOSE / RECEIVE** specified records to/from the following:

Organization: Office Ally-Insurance and or Billing

Name/Title and/or individual: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

3. **PURPOSE:**  At patient's request:

Status Report:  Counseling/Therapeutic Value:  Court/Litigation related: \_\_\_\_\_

Other (specify): Billing, demographic information

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 the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable disease, including sexually transmitted disease (e.g., Tuberculosis, HIV/AIDS related illness), mental health services, drug and/or alcohol services. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. Including provision of healthcare service requiring subsequent disclosure to effect payment. Unauthorized re-disclosure by recipient is prohibited, but may be a potential risk. I understand that generally the alcohol and/or drug treatment program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstance I may be denied treatment if I do not sign a consent form. In any event this authorization expires automatically as follows:  
1 (one) year from date of signature. \_\_\_\_\_

### SIGNATURES:

Printed Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

I am the patient's parent or legal representative for healthcare decisions.

Printed Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

### Delivery Instructions:

Mail/Courier: \_\_\_\_\_

Telephone: \_\_\_\_\_

Other: \_\_\_\_\_