

MEDICAL RECORDS RELEASE AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE COMPLETE ALL SECTIONS, DATE, AND SIGN

I. By my signature below I authorize the release of the following individuals medical records pursuant in paragraphs II, III, IV, V and VI

Name (First, Middle Initial, Last) _____

Date of Birth _____ Phone # _____ Social Security Number _____

II. Medical record specified is to be provided to:	The information is to be disclosed by:
NAME OF PERSON/ORGANIZATION/FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

- Further Medical Care
 Attorney
 School
 Research
 Personal Use
 Insurance
 Disability
 Other (Specify) _____

IV. The information to be disclosed from my health record: (check appropriate box(es))

- Only information related to (specify) _____
 For the dates from _____ to _____
 Other (specify) (CHS, Billing, etc.) _____
 Entire Record

The following sensitive information will not be disclosed unless the applicable box(es) are checked below:

- Alcohol/Drug Abuse Treatment/Referral
 HIV/AIDS-related Treatment
 Sexually Transmitted Diseases
 Mental Health (Other than Psychotherapy Notes)
 Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the CHNWF Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage, other law may provide the insurer with the right to contest a claim under the policy. **This authorization is valid for one year and all visits prior to the date of this signed document. One year after the signed date below a new authorization will need to be completed.**

VI. Records to be sent by: Fax to: _____ USPS (Mail) to: _____
 Choose one Email: _____ Picked up by: Name _____

I understand that CHNWF will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)	DATE
SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark)	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

Instructions for Completing CHNWF Form
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc.
5. Section IV, check the appropriate box as applicable.
 - a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.
 - b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.
 - c. **Other (*specify*)** -- e.g., CHS, Billing, Employee Health.
 - d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
 - e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**
 - f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
6. Section V, Authorization terminates upon release of records requested in this form.
7. Section V, Please sign (or mark) and date.
8. A copy of the completed CHNWF form will be given to you.
9. A copy of this request will be placed in patient's medical file.