Riverside University HEALTH SYSTEM Behavioral Health

Authorization for Use and/or Disclosure of Client Health Information

Completion of this document authorizes the use and/or disclosure of your health information. Please read the entire document before signing.

Client Name: *(Print)*	Date of Birth:

I hereby authorize: *(Name or general designation of person or entity making disclosure)*		**To release information *(specified below)* to:** *(Name of person or organization to which disclosure is to be made)*	
Address:		Address:	
City, State, Zip Code:	Phone #:	City, State, Zip Code:	Phone #:

This authorization is a two-way authorization and shall authorize both named parties above to exchange the protected health information stated below between each other: Yes ☐ No ☐

I authorize the following information to be released: *(Initials are required if any of the following are selected):*

Only the following records or types of health information (including any dates):

Initial: _____ Alcohol/drug testing results

Initial: _____ Assessment (Mental health and/or Substance abuse)

Initial: _____ Current/past medications and dosage

Initial: _____ Diagnosis (Mental Health and/or Substance Use Disorder)

Initial: _____ Psychological evaluation

Initial: _____ Substance Use Disorder Treatment Placement recommendation (ASAM)

Initial: _____ Treatment plans (MH/SUD)

Initial: _____ Treatment summary including attendance, progress

Initial: _____ Other: _____

PURPOSE: The disclosure must be limited to that information which is necessary to carry out the stated purposes:

Initial: _____ Develop individualized treatment

Initial: _____ To inform of attendance and progress in treatment

Initial: _____ Coordinate and provide continuity of care

Initial: _____ Other: _____

Records requested from: _____ *(Date)* **to:** _____ *(Date)*

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire one year from date of signature or as follows:

_____

(Insert specified date, event, or condition upon which the consent will expire).

NOTICE OF RIGHTS AND OTHER INFORMATION:

- I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder 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 by the regulations.
- I understand that in the case of a release to a general designation, I have the right to request a list of entities to which my information has been disclosed. I understand this request must be made in writing and limited to disclosures made in the last two years.
- I understand that I have a right to receive a copy of this Authorization.
- **TO RECEIVING AGENCY: This information has been disclosed to you from records whose confidentiality is protected by Federal Confidentiality rules. Any further re-disclosure is prohibited.**

I have read this Authorization and agree to the use and disclosure of health information specified above.

_____ Signature of Client

_____ Date Signed

_____ Signature of Client's Legal Representative (if applicable)

_____ Date Signed

_____ Print Name of Client's Legal Representative

_____ Relationship to Client

I wish to revoke authorization: _____ Date _____ Print Name of Consumer/Parent/Guardian/Conservator _____ Signature of Consumer/Parent/Guardian/Conservator