Azure for Health and Human Services, LLC

Patient Name:_______________________

Date of Birth: _______________________

Authorization for Release of Information

Section A: Use of Disclosure of Health Information

By signing this form, I authorize the use and/or disclosure of my individually identifiable health information maintained by:

Name: ____

Address: ____

My health information may be disclosed to:

Recipient's Address, phone and fax:

Section B: Scope and Use of Disclosure

Information that may be used or disclosed based on this authorization is as follows (Check **only** those applicable to **this** use or disclosure.):

___Attendence ___Drug Screen Results ___Discharge Summary ___Psychiatric Evaluation ___Plan of Care

___Physician Orders ___Lab Reports ___Physical Exam ___Nursing Assessment ___Progress notes

___Other (Specify) ____

___Information pertaining to the identity, diagnosis, or treatment for alcohol or drug abuse

___Information pertaining to the testing and/or treatment related to HIV or AIDS and any related conditions

___Privileged communications between licensed professional staff and me or between them concerning my communications with any of them

Section C: For the Purpose of:

___To meet requirements of the Court ___Probation/Parole ___DFCS Requirement ___Family Involvement

___Continuity of Care ___Other (Specify) ____

Section D: Expiration ___30 days ___90 days ___1 year from date of signature ___Other*_______________

***NOTE: If an expiration event is used, the event must relate to the consumer or the purpose of the disclosure.**

Section E: Other Important Information:

1. I understand that Azure for Health and Human Services cannot guarantee that the recipient of this information will not re-disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42CFR, Part 2).
2. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Azure for Health and Human Services.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by Azure for Health and Human Services in reliance on this authorization before written notice of revocation is received. (See Notice of Privacy Practices).

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Signature of Patient Date Time (AM/PM)

Patient's Date of Birth ____________________ Patient's Social Security Number: ____________________________________

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Signature of Parent or Legal Guardian (if applicable) Date Time (AM/PM)

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Signature of Witness (Title/Relationship to Patient) Date Time (AM/PM)

USE THIS SPACE ONLY IF A PATIENT WITHDRAWS CONSENT

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(Date this consent is revoked by patient) (Patient's signature)