Authorization to Release Confidential Information

Patient Name:	
Patient Date of Birth:	**Phone Number:**
Address:	**Email Address:**

I, _____, authorize NHBP, or _____, to release the above-named medical records information as described below. By signing this form, I authorize this organization/provider to share the indicated records with the entities named herein. This type and amount of information to be released is as follows:

This is a request for (check one):

☐ Complete Record
☐ Records dated 2 years from the last date of service
☐ Records from _____ to _____
(Start Date) (End Date)

Type of Information Authorized to Disclose (check all that apply):

☐ **Medical Records:**
Medical records often contain but are not limited to: physical examinations and clinical evaluations including any information relative to HIV, ARC, or AIDS if applicable. Treatment for any physical illness. Medical records, including scheduling histories, discharge summaries, laboratory reports, test results, diagnoses, complications, progress notes, medications, treatment plans, prognosis, recommendations and current status.

☐ **Behavioral Health Records:**
Mental Health records often contain but are not limited to: treatment for any emotional illness including any documentation such as scheduling and attendance records, psychiatric or psychological reports, psychosocial assessments, diagnoses, progress notes, medications, treatment plans and updates, discharge summaries, prognosis, inactive letters, recommendations and current status.

☐ **Substance Use Records*:**
Substance abuse records often contain but are not limited to: treatment for any drug or alcohol use including any documentation such as scheduling and attendance records, assessments, treatment plans and updates, test results, collaboration with external treatment centers, diagnoses, complications, progress notes, medications, treatment plans, prognosis and current status.
**All documentation referencing substance abuse information will NOT be included in any record request unless this box is checked*

☐ **Dental Records:**
Dental records often contain, but are not limited to, full mouth x-rays, panoramic x-rays and treatment plans.

☐ **Other Records of (Please Specify):**

_____

_____

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and use (as permitted by 42 CFR Part 2).

The above specified information may be disclosed to and used by the following:

Entity or Individual Name:	**Phone Number:**
Address:	
Email Address:	**Fax Number:**

Method of Delivery (check one):

☐Mail ☐Fax ☐USB Flash Drive* ☐Email* ☐In Person Pick Up

*There is some level of risk that a third party could see your information without your consent when receiving unencrypted electronic media or email. NHBP is not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email. Note: In the event NHBP is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).

By signing this authorization, I understand that I have the right to revoke this request by writing or calling any NHBP involved parties and requesting it be revoked. I also understand that NHBP Health and Human Services cannot take back any uses or disclosures already made with my consent. I understand that if I have authorized other entities to disclose information to NHBP Health and Human Services I have the right to revoke the request. This authorization will expire one year from the date signed unless otherwise specified here _____.

(Alternate Expiration Date or Event)

I understand that disclosure of the information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

By signing this authorization, I understand that any release of information carries with it the potential for an unauthorized release and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization.

Print Name of Patient (or Legal Representative):	**If signed by a Legal Representative, please specify relationship to patient:**
Signed Name of Patient (or Legal Representative):	**Date:**

AUHTORIZATION: This authorization is valid only for the purpose, information, agencies and persons cited above. This information release authorization had been prepared in accordance with the authority specified below.

- 45 CFR 160, 162, 164
- 42 CFR, part 2, subpart C, Section 2.31

Health Department Use Only

Date Received: _____ Initials of Receiver: _____