Authorization to Release Protected Health Information

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This authorization allows for the release and/or exchange of protected health information (PHI) between the entities listed below for the purpose of treatment, care coordination, program participation (including clinical research, day treatment, and/or residential care), or as otherwise specified. This may include sensitive information such as substance use, mental health, and other health care related information

Name: _____ Date of Birth:_____ Last 4 digits of SSN:_____

Phone Number: _____ Email: _____

If known, the facility services were received at: _____

If known, the year(s) services were received: _____

I hereby Authorize Pioneer Human Services to:

☐ Obtain information from ☐ Provide information to ☐ Conduct mutual exchange of information

Name of Facility/Program/Organization: _____

Address: _____

Provider/person_____ Phone_____ Fax _____

If conducting mutual information exchange – add second Facility/Program/Organization:

Name of Facility/Program/Organization: _____

Address: _____

Provider/person_____ Phone_____ Fax _____

I Authorize the Release of the Following Information:

☐ Discharge Summary	☐ Progress Notes	☐ All Substance Use records
☐ Psychological Evaluation	☐ Physician Orders	☐ Re-disclosure of UA results
☐ Treatment Plan	☐ Social/Occupational Hx	☐ Monthly SUD Status Reports
☐ History and Physical	☐ Medication Records	☐ SUD Assessment Summation
☐ Admission Note	☐ Psychological Testing	☐ Monthly MH Status Reports
☐ Consultations	☐ Communications	☐ MH Assessment Summation
☐ Lab Reports (ECG, blood, MRI/CT, etc.)	☐ HIV+, AIDS info / status	☐ Other, specify _____
	☐ HBV, HCV info / status	

Amount of Information to be Disclosed:

☐ Previous 3 Months ☐ Most Recent Admission ☐ Other, specify _____

Purpose: I understand that this information will be used for the following (Check all that apply)

☐ Evaluation / Treatment ☐ Legal Purposes ☐ Insurance / Billing Purposes

☐ Other, specify _____

Expiration Date of this authorization: ___/____/____

By signing below, I acknowledge that I have read this form, understand its contents, and voluntarily authorize the disclosure of my protected health information. I understand:

- I may revoke this authorization at any time in writing, except to the extent that action has already been taken based on this authorization.
- A photocopy or electronic copy of this form is as valid as the original.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected under HIPAA. However, re-disclosure of information related to substance use disorder treatment is prohibited without my further written consent under 42 CFR Part 2.
- I am entitled to a copy of this completed and signed authorization form.
- My treatment, payment, enrollment, or eligibility for benefits is not conditioned on whether I sign this form unless allowed by law.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness, alcohol/drug use and/or abuse (Title 42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis.

I hereby state that I have read and fully understand the above statements as they apply to me and do herein expressly consent to disclosure for the purpose or need and the extent or nature as stated above. I further understand that I may revoke this consent at any time in writing to designated Pioneer Human Services staff, except where disclosure has already been made, or upon the occurrence of the event: the purpose for which the disclosure is hereby authorized. I further understand the refusal to allow disclosure may be considered in violation of my parole or probation.

Signature_____ Date: ____/____/___

Signature_____ Date: ____/____/____

Legal representative if not signed by client

NOTE: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Title 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.