PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTHINFORMATION FOR PURPOSES OUTSIDE OF TREATMENT PAYMENT AND HEALTHCARE OPERATIONS

I understand **Donna Day & Night Clinic** is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize **Donna Day & Night Clinic** or his/her/its designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

I authorize _____ to release the following information

Tel # _____ Fax # _____

1. Description of the information to be used or disclosed (check as appropriate):

☐ **a. My entire record:**

I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to **(check all that apply)**:

- ☐ Alcohol and Drug Abuse Treatment*
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment
- ☐ Genetic Information (including, but not limited to, Genetic Test Results).

(NOTE: If you checked "my entire record," please skip to number 2. Otherwise, please continue with b. and c. below.)

☐ **b. My demographic information (check "All" or those that apply):**

☐ All	Age		Gender	Race	☐ Other_____
☐ Name	Address		State/Zip Code Only	Telephone	

☐ **c. Medical Data/Information as related to (check all that apply):**

- ☐ Specific condition(s):_____ Specific professio
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability
- ☐ Treatment:_____ HIV/Acquired Im
- ☐ Other: _____
- ☐
- ☐

2. Please disclose the above information to: Donna Day & Night Clinic

3. ☐ **do** ☐ **do not authorize this information to be disclosed electronically.**

4. Purpose(s) for disclosure of the information:

_____

(NOTE: If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure.")
(NOTE: An Authorization for a "Marketing" or "Sale of PHI" purpose must disclose whether remuneration is involved.)

5. **Right to revocation**. I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, STPA must receive the revocation in writing, and the revocation must include:

a. My name and address,

b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,

c. My desire to revoke this authorization, and

d. The date of the revocation, and my signature.

STPA will accept written revocations of this authorization via: Certified U.S.

☐ mail

☐ Facsimile at this number: _____

ALL revocations must be sent to_____, and are not effective until received by him/her.

6. **This authorization shall expire on_____**. After this date/event, STPA can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

7. I fully understand and accept the terms of this authorization.

Signature of Patient or Patient's Representative	**Date**
Name of Patient	**DOB:**
Name of Representative (if applicable)	**Description of Representative's authority to act for patient**

***CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). 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 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR OFFICE USE ONLY

☐ Authorization added to the patient's record on_____.

☐ Authorization verified by_____on_____.

☐ Patient has been provided with a copy of the signed authorization.