MEIER CLINICS

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____

Home/Cell Phone: (_____)_____ **Work Phone:** (_____)_____

I, the undersigned patient or legal guardian, hereby authorize verbal ❒ and/or written ❒ information to be released by:

_____
Name of Releasing Facility/Provider

_____
Mailing Address

To:

_____ ( ) _____ ( ) _____
Name of Hospital/Clinician/Third Party Phone Fax

_____
Mailing Address

Information to be released:

❒ Psychiatric Evaluation ❒ Psychosocial ❒ Discharge & Aftercare Plan
❒ Medication Record ❒ Psychological Testing ❒ Progress Notes
❒ H&P/Lab work ❒ Treatment Planning

❒ Other (specify) _____

Release of information for the following purpose(s): ❒ Treatment/Consultation ❒ Patient Request ❒ Billing/Claims

❒ Attorney ❒ Other (specify) _____

- I understand that the information released may be ***(Initial for release of the following information)***:
  _____Mental Health _____Substance Abuse _____HIV/AIDS information.
- I understand that this authorization is voluntary and that treatment by a Meier Clinics® provider cannot be conditioned on the signing of this authorization.
- I understand there may be a charge, payable in advance, for the copying and conveyance of records released.
- I understand that this authorization can be withdrawn by me in writing at any time. I cannot, however, take exception to actions that had taken place before I withdrew my consent.
- I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected. Meier Clinics® and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the information which is being released is from records whose confidentiality is protected by State and Federal Law.
- I understand I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law. I also have the right to refuse to sign this authorization.
- Refusal to sign this form will result in the following consequences**: Information will not be disclosed/obtained.**
- I understand this authorization will expire on_____(enter date or event)

_____ _____
Patient (must be signed by patient if 12 years or older) or Date
Legal Representative (description/proof of authority to act for patient must be provided)

_____ _____
Witness and Title/Relationship to Patient Date

Notice To Whomever Disclosure is made: This information has been disclosed to you from records whose protected health information is protected by State and Federal Law, including 42 CFR Part 2. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom **it pertains.**