STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*

FORM A - AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

M.I.	Last Name*		Date of Birth*	* Social Security Num		ty Number	
				• ••••			
		City		State		Zip Code	
closure of	health informa	L tion about the	above individua	l as follow	s.		
	ficulti filotific						
Section II Disclosing Entity* (Covered Entity such as a health plan/insurer or provider)							
Address				Telephone Number			
State				Zip Code			
Recipient (Person or Entity) *							
Contact Information (e.g. telephone number, email address, fax number, street address, etc.)							
Section III Reason for Disclosure*							
disclosed*							
Specify time period, if desired:							
Release only information from the period (mm/dd/yyyy) to (mm/dd/yyyy)					nm/dd/yyyy)		
Section IV							
This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may							
revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing							
entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been							
authorization will expire in one year.							
Expiration Date or Event (mm/dd/yyyy)							
• I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for							
refusing to authorize disclosure unless such denial is permitted under state and federal law.							
• I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law,							
may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and							
Accountability Act Privacy Rule [45 CFR Part 164]. Signature of Individual* Date* (mm/dd/yyyy)							
					Date	* (mm/dd/yyyy)	
Signature of Personal Representative (if applicable)* (identify relationship to individual below)			Date	* (mm/dd/yyyy)			
Relationship of Personal Representative to Individual (Personal representative shall submit proof of authority to the disclosing entity)							
epresenta	tive to Individua	l (Personal repre	sentative shall subi	mit proof of	authority to the	disclosing entity)	
	closure of Entity such () * elephone nu disclosed* ired: from the p nain in effe orization of that act that act that act che date o n one year not be de sclosure u nation disc sclosure by cy Rule [4]	closure of health informa Entity such as a health plan/ii State () * elephone number, email addra disclosed* ired: from the period nain in effect until revoked norization at any time by s nt that action has been ta the date or completion of n one year. not be denied treatment, sclosure unless such denia nation disclosed by this au sclosure by the recipient a cy Rule [45 CFR Part 164].	City closure of health information about the Entity such as a health plan/insurer or provider State State State State State State State Sisclosed* Income number, email address, fax number, s State Sisclosed* Income the period(n nain in effect until revoked or shall expire orization at any time by submitting writt nt that action has been taken in reliance the date or completion of the event stat n one year. (mm/dd/yyyy) not be denied treatment, payment, and sclosure unless such denial is permitted nation disclosed by this authorization, existence is completed at the recipient and may no lon cy Rule [45 CFR Part 164].	City closure of health information about the above individual Entity such as a health plan/insurer or provider) State () * elephone number, email address, fax number, street address, etc. disclosed* ired: from the period(mm/dd/yyyy) to	City State closure of health information about the above individual as follow Entity such as a health plan/insurer or provider) Entity such as a health plan/insurer or provider) Telephone State Zip Code /) * elephone number, email address, fax number, street address, etc.) disclosed* ired: from the period (mm/dd/yyyy) to nain in effect until revoked or shall expire on date or event specified orization at any time by submitting written revocation in the many int that action has been taken in reliance on this authorization. If the date or completion of the event stated below. If no date or even even one year.	City State closure of health information about the above individual as follows. Entity such as a health plan/insurer or provider) Telephone Number State Zip Code () * elephone number, email address, fax number, street address, etc.) disclosed* ired: from the period (mm/dd/yyyy) to(n) nain in effect until revoked or shall expire on date or event specified below. I unde orization at any time by submitting written revocation in the manner specified be not that action has been taken in reliance on this authorization. If this authorizatio, the date or completion of the event stated below. If no date or event is specified none year.	

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic,)Date Released

FORM B - CONSENT FOR RELEASE OF PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION

A Part 2 Program is a federally assisted: (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment, or referral for treatment; (ii) an identified unit within a general medical facility that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment; or, (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment; or, effect as such providers.

Section I								
First Name*	M.I.	Last Name*		Date of Birth*		Social Secur	ity Number	
Address				City		State	Zip Code	
I hereby authorize the disclosure of health information about the above individual as follows.								
Section II								
Disclosing Entity* (Name of Holder of Part 2 Program Information) Telephone Number						ber		
Address		City		State		Zip Code		
The information is to be Named Individual: Named Third Party Pa	-	the following*:						
□ Named Treatment Pr		EV:						
□ Named Treatment Provider Entry: □ Named Non-Treatment Provider (such as an intermediary or research entity) ⁺ ⁺ If non-treatment provider is selected complete a, b and/or c below.								
a. Named Individual Participant(s):								
b. Named Treatment Provider Entity Participant(s):								
c. Description of Group or Class of Treatment Provider Entity Participant(s):								
Contact Information (e.g. telephone number, email address, fax number, street address, etc.)								
Section III								
Reason for Disclosure*	Reason for Disclosure* Health information to be disclosed*:							
Specify time period, if de	esired:							
Release only information from the period			(m	<i>m/dd/yyyy)</i> to	(mm/dd/yyyy)			
Section IV								
This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.							or	
Expiration Date or Event (mm/dd/yyyy)								
 Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be redisclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient. I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services. If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation. 								
Signature of Individual*				1			(mm/dd/yyyy)	
Signature of Personal Re	precentativ	e (if annlicable)* (identifi	vrolation	hin to individual below)		Date*	(mm/dd/yyyy)	
Signature of Personal Representative (if applicable)* (identify relationship to individual below)								
Relationship of Personal Representative to Individual (Personal representative shall submit proof of authority to the disclosing entity)								
□ Parent □ Legal Guardian □ Healthcare Power of Attorney □ Executor/Administrator □ Other □ N/A								
For administrative use on	ıly:							

Method of Delivery (e.g. paper, fax, electronic)	Date Released