



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION - GENERAL

My Identification: Patient / Client / Resident / Student

LEGAL NAME: (FIRST, MIDDLE, LAST)	NAME UTILIZED AT TIME OF CARE:	BIRTH DATE:
ADDRESS:		
EMAIL:	PRIMARY TELEPHONE #:	

Who may release my Health Information?

- ☐ I hereby authorize the release of information from Sheppard Pratt and each of its hospitals, facilities, and entities.
- OR** ☐ I hereby authorize the release of information from the following Sheppard Pratt Entity, Hospital, Program, or School
- ☐ Inpatient Facility: _____
- ☐ Hospital Outpatient Program: _____
- ☐ Sheppard Pratt School: _____
- ☐ All Sheppard Pratt Community Services Programs (Mosaic Community Services, Inc., Family Services, Inc., Way Station Inc.,)
- ☐ Other Specific Sheppard Pratt Program: _____
- OR** ☐ Other Entity or Person: _____

Who may receive my Health Information?

I hereby authorize the following to receive my health information:

Name/Entity: _____

Telephone Number of Person/Entity to receive my information: _____

My health information should be sent in the following manner (check all that apply):

- ☐ Verbal communication of information
- ☐ Mailed to this address: _____
- ☐ Sent electronically (fax # or email) to: _____

What Health Information may be released?

By checking any box below, I understand that the requested medical record includes **mental health records**, which may include information related to substance use history and screenings as well as sexually transmitted diseases or HIV/AIDS history.

- ☐ **My complete medical record**
- ☐ Partial medical record only:
- ☐ Only treatment dates from _____ to _____
- ☐ Only the following checked portions:
- | | | |
|---|--|--|
| ☐ Admission Notes | ☐ Psychosocial History | ☐ Medication List |
| ☐ History & Physical | ☐ Labs/Medical Tests | ☐ Discharge Notes |
| ☐ Progress Notes | ☐ Legal Psychological Testing | |
- ☐ Other (identify portion of Medical Record to be released) _____
- ☐ Check this box only if you authorize the bi-directional transfer of information between the parties named above.



Special Sensitive Diagnosis Requests: I agree to the following:

- ☐ Disclosure of records related to my participation in a specific or integrated **Sheppard Pratt Substance Use Treatment Program**.
- ☐ Disclosure of records specifically related to diagnosis and treatment of **Sexually Transmitted Diseases and HIV-Related and/or AIDS Information** not already included in my general patient history.

Independent Requests: The release of information sought below requires a separate Release of Information form. If disclosure is requested, please initial below and submit a **separate** Release:

_____ **SUD Counseling Notes:** I agree to the disclosure of any substance use disorder counseling notes maintained outside of my medical record by the following Therapist/Provider: _____

_____ **Psychotherapy Notes:** I agree to the disclosure of any psychotherapy notes maintained outside of my medical record by the following therapist/provider: _____

Why do I want this Health Information Released?

☐ At my request ☐ Treatment/Payment/Health Care Coordination ☐ Legal ☐ _____

When does this Release Expire?

For Treatment, Payment, and Health Care Operations, this Release expires upon the discontinuation of my care. For any other reason, this Release **expires one year from the date signed** unless I request a different expiration date or event here:

Additional Terms and Agreements

- This Release is voluntary and I do not need to sign this form to receive treatment or to receive payment, enrollment, or eligibility for benefits.
- I may inspect the health information to be used or disclosed, as provided in 45 CFR §164.524.
- I may withdraw this Release by written request to Sheppard Pratt's Health Information Management team, but my revocation does not affect any information already shared pursuant to this Release.
- Health Information used or disclosed pursuant to this Release may be subject to **re-disclosure** by the recipient unless the information is protected under federal confidentiality regulations (42 CFR Part 2). Except for substance use disorder records, once information is released, Sheppard Pratt cannot prevent the recipient from further disclosing the information.
- All Sheppard Pratt entities are hereby released and discharged of any liability for complying with this Release.
- I understand that unencrypted email can be accessed, intercepted, or misdirected. By agreeing to deliver and/or receive my confidential health records by email, I agree to accept this risk and not hold the Releasor responsible for my decision to allow transmission of the records.

SIGNATURE of Person Seeking Release of Health Information (or Legally Authorized Representative*):

_____ Date: _____

*Printed Name of Legal Representative: _____

*Basis for Legal Authority (supporting documentation must be attached): _____

PROHIBITION ON REDISCLOSURE: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2. (ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or (iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).

