Sheppard Pratt
HEALTH SYSTEM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH AND/OR ACADEMIC INFORMATION

PATIENT / STUDENT INFORMATION

PATIENT / STUDENT NAME	NAME AT TIME OF TREATMENT	BIRTH DATE

ADDRESS	TELEPHONE NO. *(With Area Code)*

RELEASE OF INFORMATION

I hereby authorize: ❑ Sheppard Pratt Health System ❑ Other Facility Name: _____

to release health information from: ❑ medical record ❑ school record ❑ verbal health and/or academic information by service provider

of the above named patient / student for the following purpose: ❑ provision of services ❑ continuation of care ❑ legal

❑ other _____

To: _____

Name / Address of person / organization to which disclosure is to be made

_____

Fax information to:_____ **Fax #:** _____

Send electronically to: _____Email Address:_____

For treatment dates: _____

❑ Inpatient ❑ Residential *(specify)* _____ ❑ School *(specify)*_____

❑ Partial Hospitalization *(specify)* _____ ❑ Outpatient Program *(specify)* _____

Addiction Treatment Programs: ❑ TE Co-Occurring Unit ❑ Ellicott City Co-Occurring Unit

❑ Outpatient Co-Occurring day hospital ❑ BOS (Behavioral Observation Services) ❑ Retreat/Ruxton Co-Occurring Track

TYPE OF ACCESS AUTHORIZED:	*SELECT PORTIONS OF THE RECORD (below): OR* ❑ *Complete Record for Dates Listed Above*
❑ Copies of the record ❑ Inspection of the record	❑ Discharge Summary ❑ Admission Note ❑ History & Physical ❑ Labs / Medical Tests ❑ Discharge Information Sheet ❑ Psychosocial History ❑ Medication List ❑ Educational Records ❑ Other, specify _____
❑ Verbal communication	❑ Information regarding service provided, specify_____

This authorization will expire one year from the date signed for records below unless specific expiration event or condition is named here: _____. For verbal communication, this authorization will expire upon discharge. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this Authorization for Release of Protected Health and/or Academic Information. I understand that authorizing the disclosure of this information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524.

- **I, the undersigned**, have read the above and authorize the staff of the disclosing facility named to disclose such information as described within this document.
- **I understand** that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I may withdraw this authorization by notifying, in writing, Health Information Mangement or above specified program.
- **I acknowledge** that the material authorized for release may contain alcohol, chemical dependency, psychiatric, HIV testing or results, or AIDS information.
- **I understand** that health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2.
- I understand that, once information is released, this facility cannot prevent the recipient from further disclosing the information.

This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Protected Health and/or Academic Information".

Signature of Patient / Student _____Date _____

Signature of Parent, Guardian / Authorized Representative _____**Date** _____

Relationship to Patient / Student _____

Fees / charges will comply with all laws and regulations applicable to release of information

PROHIBITION ON REDISCLOSURE: **This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 CFR 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.**

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