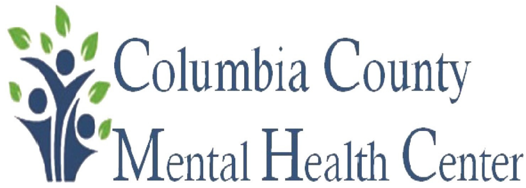

Authorization to Use or Disclose Protected Health Information

NAME OF CLIENT:	**DOB:**
NAME OF PERSON ACTING FOR CLIENT:	

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

Primary Care Physician: ______________________________

____

____

Telephone: ______________________ **Fax:** ______________________

2. to the **RECIPIENT:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged:** (check all that apply) ☐Transportation/Accessibility Needs
☐Financial/Billing ☐Admission/Assessment ☒Progress Notes ☐Service Plan ☒Diagnosis ☒Lab Results ☒History and Physical
☐Psychiatric Evaluations ☒Psychological Testing/Reports ☐Discharge Summary ☒Medication Information ☒Medical Information
☒Dates and Types of Services Received ☒**HIV+, AIDS** information ☒**HBV, HCV** information

4. **Required for disclosure of Substance Use Treatment information:**
☒**Substance Use Treatment Information/Drug Screenings**

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐Insurance/Billing Purposes ☒Care Coordination ☐Other *(specify)*______________________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Client: ______________________________ **Date:** ___/___/___

Signature of Person Acting for Client: ______________________________ **Date:** ___/___/___

REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME): **Relationship:**

Signature of Person Revoking Authorization: Date: / /

Provide the individual served with a copy Place the original in the service record

Helping Columbia County Residents Find Hope & Healing For Over 50 Years

columbiacountymhc.com