COMMUNITY HEALTH & WELLNESS PARTNERS
Care... To Live Life Fully

Phone: 937-599-1411
Fax: 937-599-4128
Email: documents@chwplc.org

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Patient Date of Birth:_____

Name of Person completing Form: _____

Relationship to Patient: _____

I, authorize Community Health & Wellness Partners (CHWP) to request, use, and/or disclose Protected Health Information as indicated below.

☐ Exchange Information With ☐ Request Information From ☐ Send Information To

Name of the party requesting or receiving information:
Address:
City/State/Zip:
Phone/Fax:
Email Address:

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that my records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. In order to revoke the Authorization for Release of Information, I will contact the Community Health and Wellness Partners' Health Information Management Department.

This Authorization will remain in effect for one year after I sign and date this form unless I specify an EARLIER expiration date in the space provided. Early Expiration Date:_____

Notice: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such information by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F. R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

(These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Amount of Information to be Disclosed:

☐ Information covering all dates of service (past, present, future)

☐ Information covering the following specified date range: _____(mm/dd/yyyy) to _____(mm/dd/yyyy)

☐ Other (specify the date of treatment or admission/discharge): Date:

_____

The purpose/need of this request is:

_____

_____

The following ***INITIALED*** information may be provided by mail, fax, in person, verbally, or by secure email:

_____All of my Physical Health Information contained in the description boxes below:

_____All of my Mental Health Information contained in the description boxes below:

_____All of my Substance Use Information contained in the description boxes below:

INITIAL **beside the information to be shared/requested**

_____ Assessment Information/ Results	_____ Progress Notes/Clinical Notes
_____ Care Plan/Review	_____ Laboratory Results/Drug Screen Results
_____ Treatment Recommendation	_____ Medication History
_____ Transfer/Discharge Summary	_____ Hepatitis C Results
_____ Financial Information	_____ HIV Results or AIDS/ARC Diagnosis Information
_____ Psychiatric Evaluation	_____ CHWP Scheduled Appointment
_____ Treatment Diagnosis	_____ CHWP Attended Appointment
_____ Treatment Progress	_____ Other: _____

_____ _____

Patient Name **Patient Date of Birth**

_____ _____

Signature of the Patient **Date of Patient Signature**

_____ _____

Print Name of the Person Authorized to Sign for the Patient **Describe Authority to Sign for Patient**

_____ _____

Signature of the Person Authorized to Sign for the Patient **Date of Signature**

For administrative use only:

Completed by: _____

Needs Faxed? Yes___ or No___

Preferred Delivery Method Paper__ Fax__ Email __ Other:_____

Date Released: _____