AUTHORIZATION FOR DISCLOSURE AND/OR TO RECEIVE PROTECTED HEALTH INFORMATION

Name: ______________________

MRN: ______________________

DOB: ____________ SSN: ____________

Email: ______________________

Phone: ______________________

I understand that I have the right to refuse to sign this authorization. I understand that treatment, Medicaid benefits, or payment processing will no be withheld if I refuse to sign this authorization.

I hereby authorize Metrocare Services at ______________________

to disclose/use/receive the specified protected health information below from the medical record of the above-named individual. **The designated staff may ☐ disclose to or ☐ receive from, the following individual or facility:**

Org / Person: ______________________

Address: ______________________

City, St, Zip: ______________________

Phone/Fax/Email: ______________________

PURPOSE OF DISCLOSURE

- ☐ Personal Use
- ☐ Treatment/Continuing Care
- ☐ Attorney / legal
- ☐ Educational Use
- ☐ Discuss with Family
- ☐ Disability
- ☐ Housing
- ☐ Other (specify) ______________________

TYPE OF INFORMATION: (check all that apply)

☐ Mental Health Records ☐ Primary Care Records ☐ Cohen Records

(From: To:)

☐ Evaluations (check all that apply)

☐ Psychiatric ☐ Psychological

☐ All Records ☐ Provider Notes ☐ Progress Notes

☐ Labs ☐ Treatment Plans ☐ Medication List ☐ Diagnosis Letter

☐ Other (specify type - discharge summary, itemized statement, etc.):

____

I also authorize the disclose/use/receipt of my health information regarding: Initials: __________

☐ HIV/Aids ☐ Sexually Transmitted Disease(s) ☐ Alcohol and Drug Abuse Treatment

EFFECTIVE TIME PERIOD:

This authorization is valid for 1 year from the date it is signed, or on ______________. If no date is specified, this authorization will expire one (1) year from the date of signature.

RIGHT TO REVOKE:

I may revoke this authorization at any time by giving written note stating my intent to revoke this authorization to the person/organization who I authorized to release or receive my health information. The revocation will be effective the date it is received by the person /organization that I have withdrawn permission from except to the extent the organization/facility has already relied upon my authorization to use or disclose my health information as described in the Notice of Privacy Practices.

SIGNATURE AUTHORIZATION:

I have read this form and agree to the uses and disclosures of information described.

Signature: ______________________ ______________________

Individual Served Date

Signature: ______________________ ______________________

Individual's Legally Authorized Representative (if any) Date

Printed Name of Legally Authorized Representative (if any): ______________________

Specify relationship to individual: ☐ Parent of Minor ☐ Guardian ☐ Other ______________________

Identity of requestor verified via: ☐ Photo ID ☐ Matching signature ☐ Other ______________________

Witness/Staff (Print): ______________________ Signature: ______________________

Note: Except for the information related to alcohol and drug abuse treatment, the information disclosed pursuant to this authorization may not be protected by medical privacy laws and may be subject to re-disclosure by the recipient.