metrocare.

AUTHORIZATION FOR RELEASE OF 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 not be withheld if I refuse to sign this authorization.

I hereby authorize Metrocare 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 organization or person:**

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 disclosure/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 reserve the right to remove this authorization at any time by providing written notice of removal to Metrocare for the named individual /facility. The removal will be effective as of the date it is received except to the extent Metrocare 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 _____

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.