AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name: ______________________ Date of Birth: ______________________

Client Address: ______________________ City/State/Zip: ______________________

Phone: ( ) ______________________ May we leave a message (check one)? ☐ Yes ☐ No

The undersigned hereby authorizes and requests the release of confidential health information **(please check)**

☐ **to the agency and individual listed below** ☐ **from the agency and individual listed below**

for review, examination and/or photocopies between **Porter-Starke Services, Inc.**, 601 Wall St., Valparaiso, IN 46383 **and**

____

Name of Person/Agency receiving records **Street Address**

______________________ ( ) ______________________ ( ) -

City,State, Zip Code **Phone Number** **Fax Number**

Access to this information is limited as designated below.

RELEASE FROM THE TIME PERIOD OF(check one): 1) Any Admissions ☐ **2) Only Specified year(s):** ______________
(specify yr)

Release Only Those Portions Of The Medical Record Checked:

☐ Assessment/Psychiatric Evaluation	☐ Progress Notes	☐ History/Physical (Inpatient)
☐ Psych/Social	☐ Discharge Summary	☐ Psychological Testing Results
☐ Lab/Drug Results	☐ Medications	☐ Financial Information
☐ Appointments/History	☐ Completion Certificate	☐ Verbal Communication
☐ Letter	Other (please specify):	

Purpose of Release (check one): ☐ Continuity of Care ☐ Other: (specify): ______________________

Date Records Needed: ________________ (**An <u>additional</u> fee will be charged for notice of records needed less than 48 hours)**

NOTE: IF APPLICABLE, PAYMENT MUST BE RECEIVED BEFORE RECORDS ARE RELEASED.

Please check one: 1) ☐ I will pick up records 2) ☐ I want records mailed to address above

I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, as required by law. I understand that records not protected by Federal confidentiality rules (42CFR Part 2) may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I cannot be required to sign this authorization as a condition for having treatment provided or obtaining payment for the same.

Date, event or condition this authorization expires: ___________. If no date, event or condition is specified, this authorization expires 60 days after services have been terminated or when all financial responsibilities have been satisfied. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written or oral revocation request to the Health Information Department.

This information may be disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit 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.

Patient Signature: ______________________________ Date: ______________________

Relationship to Patient: ______________________ Request Received by: ______________________
(if signed by responsible party)

CLIENT NAME:______________________**CLIENT NUMBER:**______________________

Form Name: P:\Forms-Current\Agency Forms\ROI Authorization for Disclosure of Protected Health Information.dot Revised date: 9-26-11

FOR OFFICE USE ONLY:

______ **SCANNING ONLY** ______ **REQUEST INFO FROM ANOTHER PROVIDER** _____**SEND OUT MEDICAL RECORDS- ROI ATTACHED**

______ **SENT OUT MEDICAL RECORDS---ROI IS ALREADY ON FILE** _____ **INFORMATION GIVEN TO CLIENT, ROI ATTACHED, PLEASE SCAN**