Duffy Health Center
94 Main Street, Hyannis, MA 02601
Phone: (508) 771-9599
Fax: (508) 771-1986

Authorization Form for Release of Protected Health Information

Please print.

Patient Name: _____ DOB: _____

By signing this Authorization, I authorize the use or disclosure of my confidential and/or Protected Health Information **maintained by**:

_____ Duffy Health Center, 94 Main Street, Hyannis MA 02601

_____ Other: _____

My health information may be disclosed under this Authorization **to**:

_____ Duffy Heath Center, 94 Main Street, Hyannis MA 02601

_____ Other: _____

SCOPE OF USE OR DISCLOSURE:

All health information about me, including my clinical records, including all psychiatric information created or received by the agency, for all dates of service. This does ***not*** include, if applicable, information pertaining to alcohol or drug abuse, or AIDS, ARC, or HIV.

Initial here if you are allowing:

_____ Written and verbal **two-way communication** of protected health information between the people/parties listed above.

_____ I wish to limit this authorization to specific date(s) of service:

_____

SCOPE OF USE OR DISCLOSURE: INFORMATION WITH ADDITIONAL PROTECTIONS

_____ Information pertaining to the identity, diagnosis, prognosis or **treatment for alcohol or drug abuse** maintained by a federally assisted alcohol or drug abuse program.

_____ Information regarding **AIDS, ARC, or HIV** including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative.

_____ I wish to limit this authorization to specific date(s) of service:

_____

<u>PURPOSE</u> OF THE USE OR DISCLOSURE:

The Purpose(s) of this Authorization is (are):

_____ Treatment Coordination

_____ Treatment Planning

_____ Other

I understand that I may withdraw this consent at any time, either verbally or in writing, except to the extent that action has been taken in reliance on it. The consent will last unless I withdraw my consent or 1 year after signature of release, whichever date which occurs first.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illnesses. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2), which prohibits the recipient of these records from making any further disclosure to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Patient Signature: _____

Date: _____

Parent/Guardian Signature: _____

Parent/Guardian Name (print): _____

Date: _____

Witness Signature: _____

Witness Name (print): _____

Date: _____

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice program, or disclose any information identifying a patient as being alcohol or drug dependent unless:

1. The patient consent in writing:
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal laws and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to the appropriate state or local authorities.

42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE/REDISCLOSURE OF THESE RECORDS.