



AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION
(Including the release of Substance Use Disorder records for all non-Treatment/Payment/Operations Purpose)

Part 1: Patient Information

Patient Name: _____ Date of Birth: _____

Part 2: Names of the Disclosing and Receiving Parties

By signing this Authorization, I authorize **Outer Cape Health Services (“Outer Cape”)** to use or disclose or receive my protected health information (“PHI”) from or to the person or organization named below, either verbally or in writing:

Organization/Individual: _____
 Address: _____ Fax #: _____ Phone: _____

Outer Cape Program: _____
 Address: _____ Fax #: _____ Phone: _____

Part 3: Description of Health Information That may be Used or Disclosed

--Select **Just One** Check Box Below--

- ALL records about me**
 ALL records about me except: _____
 Records for the date(s): _____
 Records relating to: _____
 Other: _____

If disclosing Behavioral Health Records:

- The following Behavioral Health Information:**
- | | |
|---|-----------------------------------|
| _____ Assessment | _____ Discharge/Transfer Summary |
| _____ Diagnosis | _____ Educational Information |
| _____ Psychosocial Evaluation | _____ Psychological Evaluation |
| _____ Progress in Treatment | _____ Medication Management |
| _____ Presence/Participation in Treatment | _____ Nursing/Medical Information |
| _____ Psychotherapy Notes* | _____ Other: _____ |
- (*Cannot be combined with any other disclosure)

Part 4: Authorization to Release Additionally Protected Information

Please indicate the **specific categories of information** you agree to release by checking and initialing the boxes below:

- | | |
|--|---|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Genetic Testing |
| <input type="checkbox"/> Sexually Transmitted Infections records | <input type="checkbox"/> Sexual Assault |
| <input type="checkbox"/> Domestic Violence treatment/counseling | <input type="checkbox"/> Family Planning Services |
- Alcohol or Drug Use, excluding Substance Use Disorder Counseling Notes (aka/ “**Part 2 Records**”). Federal Confidentiality Rules 42 CFR Part 2 prohibits unauthorized use or disclosure of these records
- Other(s): _____ (please specify)

Part 5: Purpose

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

- | | |
|--|---|
| <input type="checkbox"/> At my request | <input type="checkbox"/> Coordination of care |
| <input type="checkbox"/> Continuing care/treatment | <input type="checkbox"/> Insurance related |
| <input type="checkbox"/> Legal matter | |
| <input type="checkbox"/> Other: _____ | |

Part 6: Expiration

Unless revoked, this Authorization will expire upon one of the following events, whichever is later, as the case may be: 90 days from the date of signature of this form, treatment completion, at the time of the final insurance billing, or the following event/condition_____.

Part 7: Acknowledgement

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my PHI and Part 2 Records. I have been provided with a copy of the signed Authorization, and by signing below, I understand that:

1. With my signature, PHI specified above which may include Part 2 Records, will be released to the recipient designated above.
2. Outer Cape cannot guarantee that the recipient will not re-disclose my health information to a third party. The recipient may not be subject to federal laws governing the privacy of PHI or Part 2 Records.
3. I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Outer Cape except when: (i) I am receiving research-related treatment, or (ii) I am receiving health care solely for the purpose of creating information for disclosure to a third party. If either exceptions (i) or (ii) apply, my refusal to sign an authorization may result in my not obtaining treatment from Outer Cape.
4. My Part 2 Records may be redisclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.
5. I understand that I may revoke my HIPAA Authorization in writing and Part 2 consent for any purposes other than Treatment, Payment, Operations orally at any time at any time, except that the revocation will not have any effect on any action taken by Outer Cape in reliance on this Authorization prior to receipt of my written notice of revocation by Outer Cape. I may revoke this authorization by writing to the Outer Cape Compliance Officer: at 508-905-2820 or Compliance@OuterCape.org.

Part 8: Signature

PATIENT'S SIGNATURE

Patient's signature: _____ **Date of signature:** _____

PATIENT'S GUARDIAN OR OTHER LEGAL REPRESENTATIVE SIGNATURE

When patient is legally not competent or legally unable to give consent, parent, guardian, health care agent signature

Signature of legal representative: _____ **Date of signature:** _____

Print name: _____ **Relationship to Person** _____

FOR OUTER CAPE USE ONLY – DOCUMENTATION BY PERSON SENDING THE INFORMATION/FORM
 Date information/form sent/released: _____ How it was sent = mail, email, fax
 Sent by (name, title): _____ Date Signed: _____

NOTICE TO RECIPIENT(S) OF PART 2 RECORDS

This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies:

- *Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or is otherwise permitted by 42 CFR part 2;*
- *You are a covered entity or business associate and have received the record for treatment, payment, or health care operations as defined in this part; or*
- *You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E.*