FourPoints HEALTH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my
(Type/Print Name of Patient)

health record.

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other *(Specify)* _____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

_____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to FourPoints Health, except to theextent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Specify new date)

I understand that FourPoints Health will not condition treatment or eligibility for care on my providing this authorization except if such are is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a]. This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

Patient Identification:

Full Name (as it appears on the medical record): _____

Date of Birth: _____

Address/Phone: _____

Rev.06/2017

Instructions for Completing FourPoints Health
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.

2. Section I, print your name or the name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc.

5. Section IV, check the appropriate box as applicable.

   a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.

   c. **Other *(specify)*** -- e.g., Billing, Employee Health.

   d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES <u>MUST</u> BE CHECKED BY THE PATIENT.**

   f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

   g. **Alcohol/Drug Abuse Treatment Information ONLY-- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF ALCOHOL/DRUG ABUSE TREATMENT INFORMATION, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO ALCOHOL/DRUG ABUSE TREATMENT INFORMATION.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF ALCOHOL/DRUG ABUSE TREATMENT INFORMATION ONLY.

6. Section V, if a different *expiration* date is desired, specify a new date.

7. Section V, Please sign (or mark) and date.

8. Complete the Patient Identification section at the bottom.