RADIAS
HEALTH
Welcome to a full circle of care.

**Authorization Form to Obtain and Release Information**

_____
(Name) (Date of Birth)

I hereby authorize ***RADIAS Health*** **to ____ release information to, and/or ____ receive information from, the individual or organization below:**

Individual or Agency: _____ Phone:_____

1. Specific type of information to be released: (*mark appropriate areas)*

   ____ My Complete Record
   ____ Behavioral health
   ____ Primary care
   ____ Chemical health records (including alcohol/drug abuse information)
   ____ HIV related information (AIDS related testing)

2. I am requesting the release of this information for the following purposes: *(mark appropriate areas)*

   ____ Coordination of services
   ____ Care/treatment
   ____ Assessment/evaluation

3. If you would like only specific portions of the health record released, indicate the specific information to be released:
   _____

**Specific Authorization for Release of Information Protected by State or Federal Law**

- I have been instructed as to what information will be released, the purpose and intended use of the released information, who will receive the information and any known consequences of releasing this information
- I understand and agree that a copy of this authorization (e.g. electronic copy, fax, or photocopy) shall have the same force as the original.
- I understand that I have the right to revoke this authorization at any time by giving written notification to RADIAS Health. However, my revocation will not be effective if RADIAS Health has already shared the information specified in the authorization with the designated recipient.
- I understand that RADIAS Health generally may not condition services upon my signing this authorization unless the purpose is to obtain payment for my care or services are provided to me for the purpose of creating health information for a third party.
- I understand that I may inspect or copy the PHI to be used or disclosed. I understand that any disclosure of PHI carries with it the potential that the PHI may be re-disclosed and no longer protected by federal or state privacy regulations, subject to the limitations below.

*Federal and/or State Law specifically require that any disclosure or re-disclosure of substance abuse-alcohol or drug-mental health, or related information must be accompanied by the following written statement:*
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

_____ _____
Signature of Client Today's Date

_____ _____
Signature of Legal Guardian / Relationship & Authority Expiration Date

_____
Person informing client of rights

(This authorization shall remain in effect for one year or less as indicated.)

Activity #