TERRY REILLY
Your Health. Our Mission.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

FOR THE RECIPIENT OF THE INFORMATION:

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or 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 use or 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.

All boxes to be completed in FULL by the patient or the patient's authorized representative. (Please print) If not completed, request will be returned.

PATIENT INFORMATION:

Patient Name:			
Address:	City:	State:	Zip Code:
Telephone:	Date of Birth:	SS#	

I HEREBY REQUEST AND AUTHORIZE:

Name:			
Address:	City:	State:	Zip Code:
Telephone:	Fax:		

CHECK BOX: (CHECK ALL THAT APPLY)	☐ To **release**	☐ To **request**	☐ To **verbally exchange** my confidential health information to/from/with:

Name:			
Address:	City:	State:	Zip Code:
Telephone:	Fax:		

In the following manner:	**For the following purpose(s):**	**My Authorization for the use and disclosure of the following records:**	
SELECT ONE: ☐ By mail ☐ By fax (may not be secure) ☐ Copies to be picked-up which clinic____________ ☐ Other________________ ☐ CD (X-ray images may not be secure) ☐ USB ☐ Email: ______________ ☐ **Verbal communication** ☐ Uploaded to secure site	☐ To provide treatment ☐ Coordination of care ☐ To conduct an evaluation ☐ At the request of the patient ☐ Other ________________	☐ Medical ☐ Dental ☐ Behavioral Health ☐ Allumbaugh House* *** Substance Abuse Records are covered by CFR 42**	**Check all that apply:** ☐ Charges, payments, and billing information ☐ Treatment records/progress notes/summaries ☐ X-ray reports and other images ☐ Images on CD/USB ☐ Lab tests ☐ Accounting of visits ☐ Dental records ☐ AIDS or HIV information history/physical/evaluation ☐ Police/investigation reports ☐ Other ____________________________ ***For Substance abuse records-How much and what kind of info to be disclosed, including explicit description of the substance use disorder info that may be disclosed**

Created on or during the following time period: ☐ Last six (6) months ☐ Last twelve (12) months ☐ Other______________________________	**This authorization will expire on** ____________ ***Part 2 authorization release cannot be longer than reasonably necessary to serve the purpose.**

My authorization is given freely with the understanding that:

- My information may be subject to re-disclosure by the recipient and may no longer be protected by Terry Reilly Privacy Practices or applicable privacy laws.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- Terry Reilly may not condition my treatment on my provision of this authorization.
- This authorization is valid for a 12-month period from the date it is signed unless otherwise specified.
- A photocopy or fax of this authorization is as valid as the original.
- Terry Reilly, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

________________________ Signature of Patient or Responsible Party	______________ Date	
________________________ Name of Parent or Personal Representative (please print)	______________ Relationship to Patient	__________________ Name & Designation of Employee Receiving Form/Assisting Patient (please print)