DUFFY HEALTH CENTER

PH: (508)771-9599 **FAX:** (508)771-1986

AUTHORIZATION FORM FOR MEDICAL RECORDS RELEASE

PLEASE PRINT

Patient name _____ D.O.B.: _____

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

My health information may be disclosed under this Authorization to Duffy Health Center:
Provider name(s) _____
_____

SCOPE OF USE OR DISCLOSURE: ***Please initial all that apply***

_____ **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.

_____ 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.

_____ Specific health information including only (list specific dates of service if limited here): _____

PURPOSE 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. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

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 illness. 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 42CFR 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 appropriate state or local authorities.