connections
Health Solutions

Third Party Authorization to Use/Disclose Health and Substance Use Disorder Information

I, ________________________________ authorize ______________________________ to disclose my health information and substance use

(Name of patient) *(Name of provider)*

disorder records as described below.

1. Information to be disclosed. I authorize the disclosure of the following information. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use.

- ☐ All of my medical records.

Or only the medical records and/or substance use information in the following specific types of records *(please check each area)*

- ☐ Medication(s) dosing/Progress Notes
- ☐ Assessments
- ☐ Progress in Treatment/Verification
- ☐ Treatment Plan
- ☐ Psychiatric Evaluation
- ☐ Clinical Progress Notes
- ☐ Other (specify)____
- ☐ Lab Results
- ☐ Appointments
- ☐ Diagnostic Information
- ☐ Insurance Info/Demographic
- ☐ Financial
- ☐ Discharge Summary

Date of Services to be disclosed___________________________

2. Recipient: ____ *(Name of person or organization to which disclosure is to be made)*

Address: ____________________________ Phone: ________________________ Fax/Email:____

3. Purpose of disclosure:

- ☐ Continuity of Care
- ☐ Coordinating Treatment
- ☐ Emergency Contact
- ☐ Payments/Benefits
- ☐ Administration
- ☐ Other ______________________________

Information disclosed based on this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations, except that federal law prohibits the recipient from redisclosing substance use disorder information without additional consent. In some cases, state or federal law may also restrict redisclosure of HIV/AIDS or STD information, mental health information, and genetic testing information. I understand that Connections Health Solutions will not deny me treatment services if I refuse to sign an authorization to release information.

4. Expiration. I may revoke this consent in writing at any time by mail (Connections Health Solutions, Attn Medical Records, 2390 E. Camelback Rd, Suite 400, Phoenix, AZ 85016). I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate either:

- ☐ **In one year from the date of signature; OR**
- ☐ **Upon a specific date, event, or condition as listed here:**____

(Specific date, event or condition)

Patient's Signature: ____________________________________ Date: ____________________________

Print Name: ____ Date of Birth: ______________________

Medical Record Number: ________________

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: ____

Print: ____ Date: _________________________ Legal Authority: ________________________

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Patient Revocation:_____________________________________ **Date:** ______________________________

Persons receiving confidential information may not further disclose such information if the information concerns drug or alcohol use or treatment. This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. 42 CRF part 2 prohibits unauthorized disclosure of these records. 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.

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