AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

Client Name (Please Print): _____ DOB: _____

Address: _____ Phone: _____

I hereby authorize Southwest District Health to release the following confidential personal health information to be sent and/or received from the following entity/agency/individual:

Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Fax: _____

○ Send confidential personal information **TO** the above entity.

◉ Receive/Request confidential information **FROM** the above entity.

Reason for the request: _____

The following is authorized and shall be released: **(please initial)**

- ☐ Physician's/Mid-Level's Orders and Progress Notes
- ☐ Procedure Notes
- ☐ STI and HIV/ AIDS diagnosis, HIV and/or STI tests
- ☐ Pathology
- ☐ X-ray Reports
- ☐ Labs
- ☐ Immunizations
- ☐ Other: _____
- ☐ Mental Health Records
- ☐ Comprehensive Assessment
- ☐ Treatment Plan/Progress Notes
- ☐ Medication Management
- ☐ Participation in Treatment
- ☐ Alcohol/Substance Use Records
- ☐ Urinary Analysis Results
- ☐ Discharge/Transfer Summary

I understand that the information in my health record may include information about behavioral or mental health services. I understand I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. To revoke this authorization, I must submit a written revocation to office management. I understand that my care cannot be conditioned on this authorization. Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42C.F.R. Part 2; 45 C.F.R. Parts 160, 163 protections apply. I understand information disclosed by Southwest District Health pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations. SWDH is an equal opportunity provider. This authorization will expire one (1) year from the date signed.

Client Signature: _____ Date: _____

If applicable. Under penalty of perjury, you are authorized to obtain information on behalf of the minor identified.

Parent/Guardian: _____ Date: _____