ICPR Family Practice
Care • Prevent • Rejuvenate.

Authorization to Disclose/Obtain Information

(1) I authorize _____ ☐ disclose ☐ obtain ☐ disclose and obtain
(Hospital/Agency/Individual)

(2) ☐ Mental Health ☐ Social History ☐ History and Physical ☐ Treatment/Hab Plans
☐ Assessments (Specify Type) _____ ☐ Physician Orders ☐ Progress Notes
☐ Med. Administrative Records ☐ Behavioral Plans ☐ Consultations
☐ Photos ☐ Record Abstract ☐ Patient Review ☐ Other (Specify _____
☐ Lab/Radiology Report _____

Concerning the care of the below named person from DATE (or RANGE OF DATES): ☐ All Dates_____

(3) About (Name) _____ Social Security Number: _____
Date of Birth: _____ Alias: _____

(4) For purposed of: ☐ Personal Use ☐ Continuity of Care ☐ Placement Transfer ☐ Attorney
☐ State Law/Court ☐ Death ☐ Other (Specify _____

(5) Information may be disclosed/obtained: Mail, In-Person, Phone, or by Fax (For Urgent/Emergency Needs)
Restrictions if any: _____

(6) ☐ Disclose To	☐ Obtain From
Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone & Fax#	Phone & Fax#

(7) This authorization is valid until calendar date: _____
Month Day Year

(8) It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDs. **CHECK BELOW FOR EXCLUSION ONLY.**
☐ Alcohol/Substance Abuse ☐ Mental Health ☐ Developmental Disabilities ☐ HIV/AID's
☐ Other (Specify) _____

(9) I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

(10) I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to the facility record's department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

(11) Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED.
ICPR requests a maximum of 30 days for record transfers. A copying charge may apply.

(12) _____ _____
Signature of individual (age 12 and older) For highly confidential records — Date/Time

(13) _____ _____
Signature of parent/guardian (Under 18 or Disabled) — Date/Time

(14) _____ _____
Witness OR (2nd parent/guardian, if co-custodial, may sign here) — Date/Time

(15) _____ _____
Signature of staff person disclosing/obtaining information — Date/Time

Specific information about disclosures and dates shall be documented in the individual's clinical record or Disclosure Tracking System. A facsimile of this original shall have the same force and effect as the original.

The Standards for Privacy of Personally identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to a re disclosure by the recipient of the information. The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CFR Part 1. A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 1987, November 2, 1987)

NOTE: Your refusal to sign an Authorization to Disclose/Obtain Information will not prevent treatment, payment, or enrollment in a health plan or eligibility for benefits