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OWYHEE COMMUNITY HEALTH FACILITY
Authorization for Use or Disclosure of Health Information

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record.

II. The information is to be disclosed by: And is to be provided to:

Name of Facility	Name of Person/Organization/Facility
Address	Address
City/State	City/State
Phone/Fax Number	Phone/Fax Number

III. The purpose or need for this disclosure:

◯ Further medical care ◯ Attorney ◯ School ◯ Research
◯ Personal use ◯ Insurance ◯ Disability ◯ Other:_____

IV. The information to be disclosed from my health record: (*check appropriate box(es)*)

◯ Only information related to (*specify*) _____
_____

◯ Only the period of events from _____ to _____
◯ Other (*specify*) (*CHS, Billing, etc.*) _____
◯ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

◯ Alcohol/Drug Abuse Treatment/Referral ◯ HIV/AIDS-related Treatment
◯ Sexually Transmitted Disease ◯ Mental Health (*Other than Psychotherapy Notes)*
◯ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege.

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

_____
(***Specify new date***)

I understand OCHF will not condition treatment or eligibility for care on my providing this authorization except if such care is: 1) research related or 2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.
I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and Privacy Act of 1974 [5 USC 522a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (*State relationship to patient)*	DATE
SIGNATURE OF WITNESS (*if signature is thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretense shall be guilty of a misdemeanor (5 USC 522a(I)(3)).

Office use only, for Verification of Identity.

□ The individual is known to me:_____
HIM staff initials

OR

□ The individual identified by:_____
Type of identification verified

Patient Identification:

Name (Last, First, M.I.)	Record Number	Date of Birth
Address	City/State/Zip code	

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Authorization for Use or Disclosure of Health Information

Instructions for completing this form.

1. Print legibly in all fields using black ink.

2. Section I, print name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also provide the name of the person and or facility and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research related projects, etc.

5. Section IV, check the appropriate box as applicable.
   a. **Only information related to**-specify diagnosis, injury, operations, special therapies, etc.
   b. **Only the period of events from**-specify the date range, e.g., Jan. 1, 2002 to Feb. 1, 2002
   c. **Other (*specify)***-e.g., CHS, billing, employee health
   d. **Entire Record**-the complete record except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes).
   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION, ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU <u>MUST</u> CHECK THE APPROPRIATE BOX!**
   f. **Psychotherapy Notes ONLY-IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES. IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.**

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical/health record. These notes capture the therapist's impressions about the patient, and contain details of the psychotherapy conversation, which is considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limited access because they contain sensitive information relevant to no one other than the treating provider.

6. Section V, sign and ate. If a different expiration date is desired, specify a new date.

7. Section V, Authorized Representative, e.g., legal guardian, power of attorney, etc.

8. A copy of the completed Authorization for Use or Disclosure of Health Information form will be given to the patient.