Authorization for Use & Disclosure Of Protected Health Information

Johnson Health Center (JHC) Administrative Offices
134 Elon Rd Madison Heights, VA 24572
Fax: 434-929-2596

Patient Name: _____ **DOB:**_____ **Last 4 of Soc Sec#:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

I, _____ (Print Name of Person Giving Consent), **hereby authorize JHC to:**

☐ **DISCLOSE TO (give records out to) *** If checked, JHC will be "Disclosing Provider"

☐ **OBTAIN FROM (have records sent to JHC)** If checked, party named below will be "Disclosing Provider"

☐ **VERBALLY DISCUSS (may speak with)** If checked, JHC may discuss PHI as directed below.

_____/_____ _____ _____
(Name of Facility/Person/Designee) (Relation to Patient) (Phone #) (Fax #)

_____
(Address – Street, City, State, Zip Code where to mail records –or– if you will pick up records)

the following personal health information: (mark all that apply):

	Medical Office Notes		Statement of Charges and Payments		HIV / Aids / Genetic information
	Lab/X-Ray Results or Images		Alcohol/Substance Information/Drug Screen*		Psychological or Mental Health Tests/Reports/Notes
	Dental Records		Problem list, med list, immunizations, growth charts		Other:

**NOTICE:* The information approved for disclosure may be protected by Federal Regulations (42 CFR Part 2). The Federal Regulation prohibits a recipient from making any further disclosure of alcohol and substance abuse treatment information without further permission by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. This also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient and limits those who may act on behalf of a patient who has been declared mentally incompetent by a court and assigned to an individual who has been appointed the patient's legal guardian. 42 CFR permits limited disclosures about deceased patients when required by federal or state laws for the collection of vital statistics or investigation into cause of death. Any other disclosure of information identifying a deceased client as an alcohol or drug abuser is subject to the 42 CFR.

I want this information exchanged for the following purpose(s) (check all that apply):

	At the Request of the Patient or Guardian		Changing Physicians and/or Continued Treatment		Service Coordination/ Referral		Other:

This authorization covers ☐ **all information –or–** ☐ **information from** (date) _____/_____/_____to (date) _____/_____/_____

As the person signing this authorization, I understand that **1)** the Disclosing Provider and its employees, agents and volunteers, are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein, and the information may be re-disclosed by the recipient (other than as noted in 42 CFR Part 2) or lose the protections provided by law, **2)** I may revoke my consent at any time, in writing, except to the extent that the Disclosing Provider has already taken action on the original request for release of my medical information, **3)** If this form is being used to allow JHC to disclose records to another provider or other third party, I may refuse to sign this form and my signing this authorization is not a condition of me receiving treatment from JHC, **4)** if the records copied are for my own use, I am responsible for a fee for copies as follows: for hard copies: $.50/pg for 1-50 pages plus $.25/pg for pages 51+, for electronic copies: $0.25/CD; plus a handling fee of $10; plus the cost of postage, if applicable; and there is no charge if records are sent to a provider or facility for on-going care or follow-up treatment, **5**) CDs or emails containing my medical information will not be encrypted or password-protected, and **6)** I will be given a copy of this signed consent upon my request.

Unless revoked earlier, this Authorization will expire on the following date, event or condition: _____.
If no expiration date, event, or condition is entered, this authorization will expire 1 year from the date signed.

_____
(Signature of Person Giving Consent) (Date)

My relationship to the patient is: ☐ **Self** ☐ **Parent** ☐ **Power of Attorney** ☐ **Legal Guardian**
(POA or LG must provide documentation of authorized relationship)

Staff Use: Identification presented: DL _____ State ID _____ Other: _____ Staff Name: _____
Medical Records Mailed/Picked up: Date_____ By_____ MR Staff: _____