



**AUTHORIZATION FORM FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

PATIENT'S NAME:	BIRTHDATE:	ADDRESS:
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CHECK ONE:

I HEREBY AUTHORIZE THE E.C. TYREE HEALTH & DENTAL CLINIC TO USE/ AND OR DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING:

_____ For treatment date(s): _____ to _____
 Name of person/organization Starting Date Ending Date

For the following purpose(s): _____ If the request is initiated by the individuals (or his/her representative), insert "at the request of individual"; otherwise, described purpose of the use or disclosure. If the purpose relates to marketing, indicate whether E.C. Tyree Health & Dental Clinic will receive remuneration.

PLEASE CHECK THE TYPE OF INFORMATION AUTHORIZED TO USE AND/OR DISCLOSE

- | | | |
|---|--|--|
| <input type="checkbox"/> Demographic Information
<input type="checkbox"/> Payment Records
<input type="checkbox"/> Lab Test Results
<input type="checkbox"/> Admission History & Physical
<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Operative/Procedure Reports
<input type="checkbox"/> Imaging/Radiology Reports | <input type="checkbox"/> Physician Progress Notes
<input type="checkbox"/> Physician Orders
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Nursing Notes
<input type="checkbox"/> Billing Records
<input type="checkbox"/> Therapy Notes
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Entire Record (will not include billing records not prepared by or on behalf of the Tyree Clinic unless selected)

<input type="checkbox"/> Records not prepared by or on behalf of the Tyree Clinic. The Tyree Clinic can't be responsible for the completeness or accuracy of such records. |
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This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified record expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for six months after the date listed below.

___ 1) I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug abuse Patient Records, 42 CFR Part 2, and can't be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as stated above.

___ 2) I understand that may include information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes);

___ 3) I understand this may include information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations.

By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization.

I, the undersigned, have read the above and authorize the disclosure of such records as described. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations.

I understand that the Tyree Clinic may charge fees to provide copies of records. I understand that I may revoke this authorization at any time by providing a written notice to the Clinic Director.

 Date Signature of Individual/Individual Representative Printed name of representative and relationship

 Representative address and telephone number Signature of Interpreter (If applicable) **Copy to Client's file**