Authorization to Use, Disclose, and/or Receive Protected Health Information

Client Information

Client Legal Name: _____ D.O.B.:_____

Healthcare Provider, Person, or Agency

I authorize Newport Healthcare/PrairieCare to (select one or both)

_____ Receive the information indicated below from:

_____ Release the information indicated below to:

Name: _____ Relationship to Client _____

Address: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Method of Communication (select one or both)

_____Written Communication

_____Verbal Communication

Information to be Released (select one or more)

_____ Acknowledgement of Client Receiving Services

_____ Clinical Assessment/Diagnostic Assessment

_____ Discharge Planning and Summary

_____ Psychiatric Evaluations

_____ Treatment Plans

_____ Medical History and Physical

_____ Progress Notes

_____ Transcripts/School Records

_____ Drug Test Results

_____ Substance Use Disorder Treatment Information

_____ Reproductive Health Information

_____ Psychological Consults/Evaluations

_____ Financial/Billing Records

_____ **ALL RECORDS**

_____ Other: _____

Purpose of the Release of Information (select one or more)

_____ Coordination of Care

_____ Assessment/Evaluation

_____ Treatment, Payment, and Health Care Operations

_____ Other: _____

_____ Legal

_____ Education

_____ Discharge Planning

Statement of Authorization

- I understand that my signature on this document authorizes that the above information may be disclosed to the specified entity.
- I understand that I may revoke this authorization in writing at any time. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that I may revoke consent by sending my request in writing to Newport Healthcare's Privacy Officer at privacy@newporthealthcare.com.
- I understand that signing this authorization is voluntary, and I can refuse to sign this authorization without affecting my treatment, eligibility for benefits, or payment status.
- I understand that once authorized information is released, Newport Healthcare/PrairieCare cannot prevent the redisclosure of that information. I understand that if I my records include substance use disorder treatment information that is protected by the Confidentiality of Substance Use Disorder Patient Records Rule (Part 2) and I authorize disclosure of my information to my treating healthcare providers, my health plans (insurers), other third-party payers, and their business associates (vendors), these entities may redisclose this information as permitted by the HIPAA Privacy Rule, including (but not limited to) for treatment, payment, and health care operations, **except that** the information cannot be used or disclosed for civil, criminal, administrative, or legislative proceedings against me.
- I understand that I have a right to receive a copy of this authorization form.
- I understand that this authorization will take effect immediately and, unless I revoke my consent, will expire one year from the date of my signature or:

_____

(Specify date, event, or conditions that cause authorization to expire)

Client Signature Date

Parent/Guardian Signature (if applicable) Date

Parent/Guardian Name (if applicable) Relationship to Resident/Client

Requests for medical records can be sent to:

Newport Healthcare Medical Records Department – medrecordsrequest@newporthealthcare.com

PrairieCare Medical Records Department – medicalrecordsrequest@prairie-care.com