TriState Health

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Purpose or need for Disclosure (Check all applicable categories) ❑ Attorney ❑ Insurance ❑ Provider ❑ Personal ❑ Other _____

Patient Name _____ Date of Birth ____/____/_____

Phone # _____ Phone Type _____ Email _____

I hereby authorize TriState Health to disclose records obtained in the course of my evaluation and/or treatment to (Name and address of person or organization to which disclosure is to be made):

Name _____ Phone # _____ Fax # _____

Mailing Address _____ City _____ State _____ Zip _____

Records Requested-Description:	Date(s) or a Specific Provider/Clinic
❑ **Provider notes, Diagnostics** No charge for first request of above records to patient or for continuation of care. Patient request for the same information within a 12-month period will incur a charge of $6.50, plus tax. **Transfer of care and personal requests will include the last two years of the above, unless date range specified in Date(s) field*	
❑ **Entire Record $6.50 (all documents in the medical record)*** Description of requested records: ❑ Provider notes (discharge summary, emergency, history and physical, consults, operative/ procedure notes, progress notes, office notes) ❑ Imaging/radiology ❑ Medication/immunization record ❑ Diagnostics (labs/pathology/radiology, respiratory therapy, sleep lab) ❑ Face sheet ❑ Other_____ ❑ Radiology images on CD ❑ **Billing records**	Date(s) or a Specific Provider/Clinic

Unless otherwise indicated below, I authorize the release of information regarding testing, treatment and diagnosis, to include: alcohol and drug abuse, sexually transmitted infections, HIV/AIDS, genetics and mental/behavioral health. **This does not apply to records of treatment by a Behavioral Health provider.**

❑ DO NOT INCLUDE THE ABOVE SENSITIVE RECORDS IN THIS RELEASE. (Please initial)_____

This section requires completion only when the request is for release to a person or entity other than the patient or legal representative (Healthcare Power of Attorney, Legal Guardian, Healthcare Representative Listed in an Advance Directive.)

FOR SUBSTANCE USE DISORDER AND BEHAVIORAL HEALTH TREATMENT RECORDS, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

This authorization is valid until ____/____/_____ OR when the following event occurs _____. If left blank, this authorization shall become invalid and expire 90 days after date signed. Authorization to disclose your information to an employer or financial institution can only be effective for a maximum of one (1) year from the date signed by the patient or legal representative.

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your records. Such re-disclosure will no longer be protected by this authorization. Federal or State laws may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.
2. I have the right to receive a copy of this authorization and there may be a charge for the medical records.
3. A copy or facsimile (fax) of this authorization is as valid as the original.
4. TriState Health may not condition treatment, payment, enrollment or eligibility for benefits if I choose not to sign this form..
5. I may revoke this authorization in writing, at any time, by sending a written request to Marci Kelley, HIM Director, POB 189, Clarkston, WA 99403. The only exception is when TriState Health has taken action in reliance on this authorization or the Authorization was obtained as a condition of insurance coverage.

I hereby release TriState Health from any and all legal liability and injuries that may arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. mail service, electronic facsimile and/or secure email, in accordance with the facility's policies.

I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated.

_____ _____ Date ____/____/____

Signature of Patient/Legal Guardian/Representative* Relationship

**Authorized representative must submit copies of legal documents supporting his or her authority to act on the patient's behalf.*

OFFICE USE ONLY:

ID Verified_____Completed By _____ Date Completed ____/____/____

Print name and initial

ROI#_____ Medical Record #_____ # of CD's/pages_____ Charge for Copies/CD_____ Sales Tax_____

Fax # 509.758.3566 DO NOT fax more than 20 pages.

TriState Health

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name _____ Date of Birth ____/____/_____

Phone # _____ Phone Type _____ Email _____

I hereby authorize TriState Health to disclose records obtained in the course of my evaluation and/or treatment to (Name and address of person or organization to which disclosure is to be made):

Name _____ Phone # _____ Fax # _____

Mailing Address _____ City _____ State _____ Zip _____

Psychiatric/medical/alcohol/drug abuse evaluation

Records requested:

_____ Psychiatric/medical/alcohol/drug abuse discharge summary

_____ Progress notes

_____ Psychological testing

_____ Psychotherapy notes

_____ Educational testing

_____ Medical tests/studies (Labs/Pathology/Radiology, Respiratory Therapy, Sleep Lab)

_____ Other_____

Purpose or need for Disclosure (check all that apply)

❑ Attorney ❑ Insurance ❑ Personal ❑ Provider ❑ Other (specify)_____

Requests for release of mental/behavioral health specific visits, to include psychotherapy notes, must be approved by the treating provider, prior to release.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time, by sending a written request to Marci Kelley, HIM Director, PO Box 189 Clarkston, WA 99403, except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically. Please describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent

_____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment,

or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have been provided a copy of this form.

I hereby release TriState Health from any and all legal liability and injuries that may arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. mail service, electronic facsimile and/or secure email, in accordance with the facility's policies.

I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated.

_____ _____ Date _____/_____/_____

Signature of Patient/Legal Guardian/Representative* Relationship

**Authorized representative must submit copies of legal documents supporting his or her authority to act on the patient's behalf.*

NOTICE OF PROHIBITION ON RE-DISCLOSURE OF PART 2 RECORDS

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. 42 CFR 2.32 (Updated July 2020); see Confidentiality of Substance Use Disorder Patient Records, 85 Fed. Reg. 42986, 43037 (July 15, 2020), https://www.federalregister. gov/d/2020-14675/p-644.