Heart Spring Health

Authorization to Release Confidential Information

Patient Name *(Please Print)* _____ Patient DOB *(Please Print)* _____

I authorize Heart Spring Health: ☐ To Obtain and/or ☐ To Release information as indicated below ☐ For Continuity of Care

Name of Person, Clinic and/or Agency: _____

Mailing Address: _____ City/State: _____ Zip code: _____

Telephone: _____ Fax Number: _____

The Purpose of this Authorization is: ☐ Assessment ☐ Treatment ☐ Coordination of Care ☐ Insurance ☐ Continuity of Care

Purposes (e.g., authorization for treatment, billing, coordination of benefits, quality improvement and utilization review)
Other: _____

By ***initialing*** below, I specifically authorize the release of the following information. Information may be transmitted via photo-copied records; fax, telephone or other electronic means; and/or verbal communication unless noted otherwise below:

____ Medical or psychological reports	____ Treatment plan	____ Medications used in treatment
____ Progress notes	____ Laboratory tests	____ Individualized Educational Plan
____ Physical exams	____ Treatment summary	____ Other _____
____ Diagnosis	____ Discharge summaries	_____
____ Substance use information*	____ HIV information*	____ All

*If part of the information to be released includes HIV and/or alcohol & drug information, you must specifically initial the corresponding section in order to comply with federal and state regulations.

Specific conditions, limitations, or time periods of the information to be released: _____

I understand that my records are protected under federal privacy and confidentiality regulations (including alcohol & drug and HIV disclosure restrictions) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The conditions of this form have been explained to me and my questions have been satisfactorily answered. I understand that I am not obligated to sign this release form, and that I may revoke this authorization at any time with the exception of action already taken based on my previous approval. Unless otherwise noted, this release will be considered valid for one year from the date signed, or while I am still active in treatment with _____. This release will also be considered valid for a period reasonable for the processing of a request for information, a payment claim, or quality improvement review.

Signature of Client / Legal Guardian _____ Date _____

Signature of Provider _____ Date _____

Printed Name of Provider _____

This authorization to release confidential information was revoked by the above stated client or legal guardian on: _____ Certified by: _____ Date *(MM/DD/YYYY)* Provider

To the Recipients of Confidential Information The information that has been disclosed to you from this authorization is protected by federal (Title 42 of the Code of federal regulations) and State (ORS 179.505) laws and regulations. Any re-disclosure by you must be authorized by written consent of the person to whom it pertains, or in accordance with the federal and state laws and regulations.