CHL: Release of Information Authorization Form

Client's Home Address

Client Name:

Client ID:

Date of Birth:

Street 1:

Street 2:

APT/Suite:

City:

State/Province:

Zip:

Client's Home Phone:

By signing this Authorization, I authorize the use/ access and/ or disclosure of my/ the client named above, for whom I am a parent, legal guardian, invoked health care proxy, or other legal healthcare representative confidential and/or Protected Health Information maintained by: **Community Healthlink, Inc**.

The Authorization applies to the services I received at the following CHL programs (check one):

Programs that receive Federal assistance for substance addiction treatment MUST be listed below if applicable.

☐ **All Programs at CHL**

☐ **Only the programs listed below**

Name(s) of Program:

My health or other protected information may be (check all that apply):

☐ **Disclosed to** ☐ **Obtained from** ☐ **Allow 2 way communication**

Recipient Name and Title:

Recipient Address:

Recipient Phone:

Recipient Fax:

This Authorization applies to the following dates of service:

(if nothing is specified, the Authorization shall be considered valid for all dates of services)

PURPOSE OF THE USE OR DISCLOSURE

Purpose of the Use or Disclosure (check one):

☐ **Initiated by the client, and the client does not elect to disclose its purpose**

☐ **Treatment Coordination** ☐ **Treatment Planning** ☐ **Other**

SCOPE OF USE OR DISCLOSURE. PLEASE CHECK ALL THAT APPLY

I understand that my health record may include information related to my mental health, alcohol/substance use disorder, sexual assault, sexually transmitted diseases, abortion, genetic testing, HIV/AIDS, domestic violence, or other information I may consider sensitive. You must check the box next to the types of content below that can be shared with the other party or that information will NOT be released.

☐ Abortion ☐ Genetic Screening Test Results ☐ Sexual Assault Counseling

☐ Domestic Violence Counseling ☐ HIV/AIDS test results ☐ Sexually Transmitted Diseases

☐ Details of Mental Health Diagnosis and/or Treatment Provided by a Psychologist, Psychiatrist, Mental Health Clinical Nurse Practitioner, Licensed Mental Health Counselor, and Licensed Social Worker.

☐ Alcohol/Substance Use Disorder; must specify the exact nature of information needed: ☐ **Diagnosis**

☐ **Prognosis** ☐ **Treatment** ☐ **Identity** ☐ **Other:**

☐ Other (specify):

EXPIRATION

Insert applicable event or date (mm/dd/yy) not to exceed one year after date of signature. I understand that if no date is identified, this authorization expires one year after date of my signature.

Date of Expiration:

Other Important Information

1. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Community Healthlink, except when I am (i) receiving research-related treatment or (ii) receiving health care solely for the purpose of creating information for disclosure to a third party or (iii) receiving substance use disorder treatment from a federally assisted program, which requires consent for my insurer in order to have services paid by the insurer. If any of these exceptions apply, my refusal to sign an authorization can result in my not obtaining treatment (or payment, if applicable) from Community Healthlink.

2. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by Community Healthlink in reliance on this Authorization before written notice of revocation is received by Community Healthlink. I further understand that I must provide any notice of revocation in writing to: Privacy Officer, 72 Jaques Avenue, Worcester, MA 01610.

3. I understand that information protected by federal confidentiality rules of substance addiction disorder treatment (42 CFR part 2) cannot be disclosed by the identified recipient without my express written consent. The federal rules prohibit the recipient of this information from making any further disclosure of information in this record that identifies a patient as having or having had a substance addiction/use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2.

4. Health information includes information collected from me or created by Community Healthlink, or information received by Community Healthlink from another health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

5. I understand that once the information I have consented to is disclosed by Community Healthlink to the above-named recipient, CHL can no longer accept responsibility for the information's privacy, and there is no guarantee that the information will be protected by HIPAA or other federal and state privacy rules.

6. I understand that I will be offered a copy of this Authorization, once completed.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health or other designated information. If electronically signed, my e-signature shall be considered as valid as an ink signature.

Legal Guardian or Proxy

If the client has a legal guardian or proxy (check one):

☐ **Copy of documentation attached to authorization** ☐ **Documentation on File**

☐ **N/A**

Signature of client/parent/legal guardian: Type your name below if agreeing to the authorization

Signature:

Date of Signature: Type date below

Date: