COMMUNITY HEALTH & WELLNESS PARTNERS
Care... To Live Life Fully

STANDARD AUTHORIZATION FORM – RELEASE OF INFORMATION

(Authorization for CHWP to send patient records)

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis of treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*

FORM A – AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

Section I

First and Last Name*: Date of Birth*: SSN:

Address:

I hereby authorize the disclosure of health information about the above individual as follows:

Section II

Disclosing Entity* *(Covered Entity such as health plan/insurer or provider)*

Community Health & Wellness Partners

Address		**Telephone Number**
4879 US Rt. 68 South		937-599-1411
City	**State**	**Zip Code**
West Liberty	OH	43357

Recipient (Person or Entity) *

Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)*

Section III

Reason for Disclosure* ____ Proof of Care ____Transfer of Care ____ Continuity of Care ____ Other:

Health information to be disclosed*

Specify time period, if desired:

Release only information from the period _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been take in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event _____ *(mm/dd/yyyy)*

* I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.

* I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Park 164).

Signature of individual*	**Date*** *(mm/dd/yyyy)*
Signature of Personal Representative (If applicable) * *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship to Personal Representative to Individual *(Personal representative shall submit proof of authority to the disclosing entity)*

[ ]Parent [ ]Legal Guardian [ ]Healthcare Power of Attorney [ ]Executor/Administrator [ ]Other [ ]N/A

Below section for staff use only:

*Completed by:	*Needs completed?	*Delivery method:	*Date Released
	YES NO	Paper Fax Portal Other:	

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FORM B – CONSENT FOR RELEASE OF PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION

A Part 2 Program is a federally assisted: (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment, or referral for treatment; (ii) an identified unit within a general medical facility that holds itself out as proving, and provides, SUD diagnosis, treatment, or referral for treatment; or, (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment, and who are identified as such providers.

Section I

First and Last Name*: **Date of Birth*:** **SSN:**
Address:

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

Disclosing Entity* *(Name of Holder of Part 2 Program Information)*		**Telephone Number**	
Community Health & Wellness Partners		937-599-1411	
Address	**City**	**State**	**Zip Code**
4879 US Rt. 68 South	West Liberty	OH	43357

The information is to be provided to the following*:

[ ] Named Individual:
[ ] Named Third Party Payer:
[ ] Named Treatment Provider Entity:
[ ] Named Non-Treatment Provider (such as an intermediary or research entity)*
* If non-treatment provider is selected, complete a, b, and/or c below.
a. Named Individual Participant(s):
b. Named Treatment Provider Entity Participant(s):
c. Description of Group or Class of Treatment Provider Entity Participant(s):

Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)*

Section III

Reason for Disclosure*	**Health Information to be disclosed*:**

Specify time period, if desired:
Release only information from the period *(mm/dd/yyyy)* to *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event *(mm/dd/yyyy)*

* Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to the Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient.
* I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services.
* If I have authorized disclosure to a generally described group or class or participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation.

Signature of Individual*	**Date*** *(mm/dd/yyyy)*
Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual *(Personal representative shall submit proof of authority to the disclosing entity)*
[ ] Parent [ ] Legal Guardian [ ] Healthcare Power of Attorney [ ] Executor/Administrator [ ] Other [ ] N/A

Below section for staff use only:

*Completed by:	*Needs completed?	*Delivery method:	*Date Released
	YES NO	Paper Fax Portal Other:	