

NORTHLAND CLINIC

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby freely and voluntarily authorize Northland Clinic to...

_____ Release/disclose my protected health information to:

_____ Obtain information from:

Individual, Facility, or Organization

Address

City, State, Zip Code

Telephone Number

FAX Number

The purpose of this disclosure is:

_____ insurance

_____ educational planning

_____ legal

_____ medical

_____ discharge planning

_____ continuity of service

_____ other (explain) _____

Information to be disclosed or obtained:

_____ discharge summary

_____ psychiatric evaluation

_____ mental status

_____ history and physical

_____ psychological testing

_____ treatment plan

_____ lab/X-ray report

_____ progress report

_____ psychosocial assessment

_____ immunization record

_____ physician order

_____ substance abuse tx

_____ aftercare plan

_____ other (explain) _____

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or HIV/AIDS and/or tuberculosis. I understand that such information is confidential and is protected by Federal law. I understand that the provision of health information to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice to NLC, except to the extent that action has already been taken in reliance on it. This authorization will expire 180 days () following discharge, or () following signature unless another date or condition is specified.

Other date or condition specified: _____

Patient (or parent/guardian) signature

Date

Relationship to patient

Witness