Authorization for Disclosure (Release) of Protected Health Information

I hereby authorize the use and disclosure of protected health information about me as described below.

_____ _____ _____ _____

Patient's Name (First) (Last) Maiden / Other names used Date of Birth mm/dd/yyyy

_____ _____ _____ _____ _____

Patient's Street Address City State Zip Code Home/ Work/ Cell Phone

Release records FROM: (may e-mail / fax ☐Yes or ☐No)	Address	City, State Zip Code	Phone Number	Fax Number
❒ Cass County Health Clinic (Physician Clinic, MAT, SUPR, Behavioral Health)	331 South Main 1501 Wall Street	Virginia, IL 62691 Beardstown, IL 62618	P:217-452-3057 P:217-323-2242	F:217-452-7814 F:217-323-2210
❒ Cass County Public Health	331 South Main 1501 Wall Street	Virginia, IL 62691 Beardstown, IL 62618	P:217-452-3057 P:217-323-2182	F:217-452-7245 F:217-323-2196
❒ Cass Co Home Health / Cass Schuyler Area Hospice	331 South Main	Virginia, IL 62691	P:217-452-3057	F:217-452-7245
❒ Cass County Dental Clinic	331 South Main	Virginia, IL 62691	P:217-452-3057	F:217-452-7814

Send TO:	Address	City, State Zip Code	Phone Number	Fax Number

1. **Specific description of information to be used/disclosed:** ❒Medical Record (last 24 months for transfer of records) **OR**
   Dates from: _____to_____ ❒ Other- _____
2. **The information may be used or disclosed for each of the following purposes:**
   ❒ Change in Physician/Provider ❒ Share Treatment Plan ❒ Coordinate Treatment with other providers, Bill Insurance for Payment, Allow audits and other Healthcare Operations ❒ Other_____
3. 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. Upon my request I will be given a list of entities to which my information has been disclosed. I understand that other types of information used or disclosed may be subject to re-disclosure by the person(s) / class of person(s) receiving it and no longer protected by the federal privacy regulations and that entity is not liable for any consequences of such disclosures.
4. I understand that I may revoke this authorization by notifying the Privacy Officer in writing. If I revoke this authorization, it will not have any effect on actions taken before I revoked it. I understand that I have the right to inspect and copy the information to be disclosed. 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 understand this authorization will expire in one year OR on _____.

RELEASE OF HIGHLY CONFIDENTIAL INFORMATION: If you want any of the following released / disclosed, and you are **12 years of age or older**, you must initial what you want disclosed; otherwise this information can not be included in the released.

Initials _____ mental health,
Initials _____ developmental disability,
Initials _____ alcohol and/or drug abuse – **Attention Receiving Entity:** 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

Initials _____ reproductive health information, genetic testing, sexually transmitted diseases including HIV/AIDS,
Initials _____ child or adult abuse and neglect,
Initials _____ sexual assault, adult disabilities,
Initials _____ sexually transmitted diseases and infectious diseases including HIV/AIDS.

If you do **not** wish certain information to be released, **state information to be excluded**:_____

I have read and understand the terms of this Authorization and I hereby knowingly and voluntarily authorize above Releasing Entity to use or disclose my health information in the manner described above.

☒ _____ _____ _____ _____

Signature of Patient 12 or over / Legal Guardian OR Authority to Act on Patient Behalf if not Patient | Date mm/dd/yyyy | PLEASE PRINT Name of Person Signing this Authorization **if not Patient** | Relationship

Electronic Signature Agreement

By selecting the "I Accept" button, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature and by selecting "I Accept" you agree that your electronic signature on this document (hereafter referred to as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature. **I ACCEPT**