HIPAA COMPLIANT ROI FORM

Section A: This section must be completed for all Authorizations.

Patient Last Name:	First Name:	Phone:
Date of Birth:	Email:	
Address:		
City:	State:	Zip:

Recipient Name:	Relationship:	Phone:
Fax:	Email:	
Address:		
City:	State:	Zip:

I hereby authorize the use or disclosure of protected health information as described below. Description of information being disclosed for the following date(s) of service:

Requires Specific Authorization (initial all that are approved) ___ Substance Abuse **(protected by Federal Regulation)** ___ STD/HIV/AIDS related records ___ Sexual Assault reports or testing ___ Genetic Testing related records ___ Mental Health and/or Psychiatric conditions	__ **Complete Health Record** *If not the complete health record, please select the elements you give permission to release.* ___ Progress Notes ___ Nutrition/Dietary ___ Nursing/Medical Information ___ Educational Progress ___ Treatment Plans	___ Labs/Test Results/Orders ___ Discharge/Aftercare Plan ___ Medication ___ Billing Records ___ Return to Work Status ___ Service Date(s) ___ Assessment(s) ___ Other
Purpose of the Disclosure (Example: "At the request of the patient"):		
How would you like to receive the records?	fax encrypted email	mail other:

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this Authorization expires within sixty (60) days. Otherwise, you may select either of the following expiration events.

1 year from the date in which I, or my legal representative, signs this Authorization.

Upon the happening of the following event (Example: "Upon release of the above records"):

I understand that:

1. I may revoke this Authorization at any time by providing written revocation to ERC Pathlight. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.

2. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.

3. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.

4. I have the right to inspect or copy the health information to be used or disclosed pursuant to this Authorization.

To be completed by the organization if this authorization is for marketing, fundraising, research, or sale of protected health information:

The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above. ___ Yes ___ No

Signatures: I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient: Date:

Signature of Representative or Guardian: Date:

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

Power of Attorney Executor or Personal Representative Legal Guardian Parent

Surrogate Decision-Maker Other:

For internal use only. Records were delivered by:

Fax _ Mail __ Personal Delivery on the date of: