



AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A: This section must be completed for all Authorizations

Patient Last Name: _____	Patient First Name: _____	Patient Date of Birth: _____
Phone: _____	Email: _____	
Address: _____		
City: _____	State: _____	Zip: _____
ERC Pathlight Treatment Location/Facility: _____		ERC Pathlight Date(s) of Treatment: _____
Purpose of Disclosure (e.g., at patient's request): _____		

I hereby authorize Eating Recovery Center / Pathlight Mood & Anxiety Center to (check all that apply):

- Exchange with
 Release to
 Obtain from

Recipient Name: _____	Relationship to Patient: _____	
Phone: _____	Email: _____	
Address: _____		
City: _____	State: _____	Zip: _____

I hereby authorize the use or disclosure of following health information:

Complete Health Record

Records related to the following require specific authorization to be released:

- Substance Abuse Treatment
 Genetic Testing
 STD/HIV/AIDS
 Mental Health and/or Psychiatric Conditions
 Sexual Assault Reports or Testing

ONLY the Following Health Records (check all that apply):

- Progress Notes
 Discharge/Aftercare Plan
 Nutrition/Dietary
 Medications
 Nursing/Medical Information
 Billing Records
 Educational Progress
 Service Date(s)
 Treatment Plans
 Assessment(s)
 Labs/Test Results/Orders

Other: _____

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section B: The method in which you would like records delivered

Encrypted Email

Email Address: _____

Unencrypted Email

Email Address: _____

Flash Drive to the Address Listed Above (*software to unencrypt may be required*)

Fax (*requested information must be under 50 pages*)

Fax Number: _____

Paper – via Mail to the Address Listed Above

Section C: Expiration and Revocation

If the health information to be disclosed contains HIV/AIDS or substance 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 (*e.g., "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.

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

Patient Name (printed): _____

Patient Signature: _____ **Date:** _____

Representative/Guardian Name (printed): _____

Representative/Guardian Signature: _____ **Date:** _____

Relationship to Patient:

- Parent/Legal Guardian Surrogate Decision-Maker
- Power of Attorney Other: _____
- Executor or Personal Representative