CLINCH RIVER HEALTH SERVICES

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Information				
First Name:	**Last Name:**	**Date of Birth:**	**Last 4 of SSN:**	
Address:		**City**	**State**	**Zip Code**

I AUTHORIZE **CLICH RIVER HEALTH SERVICES, 17285 VETERANS MEMORIAL HWY, DUNGANNON VA**
PHONE: 276-467-2201 FAX: 276-467-2673

TO OBTAIN MY MEDICAL/MENTAL/BEHAVORIAL HEALTH INFORMATION FROM:

FACILITY: _____

ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED [ ] OR RECEIVED[ ]

[ ] HEALTH RECORDS LIMITED TO DATES OF SERVICE _____
[ ] OFFICE NOTES [ ] LAB RESULTS [ ] XRAY REPORTS [ ] PAP [ ] MAMMOGRAMS
[ ] MEDICATION INFORMATION [ ] EYE EXAMS [ ] IMMUNIZATIONS
[ ] ALL MEDICAL RECORDS **INCLUDING** SUBSTANCE ABUSE, MENTAL HEALTH, AIDS/HIV TREATMENT/DIAGNOSIS
[ ] ALL MEDICAL RECORDS **EXCLUDING** SUBSTANCE ABUSE, MENTAL HEALTH, AIDS/HIV TREATMENT/DIAGNOSIS

REASON FOR DISCLOSURE: [ ] AT REQUEST OF PCP FOR COORDINATION OF CARE
[ ] CHANGING PHYSICIANS TO _____ [ ] INSURANCE/WORKERS COMP
[ ] LEGAL REASONS _____ [ ]SECOND OPINION
[ ] OTHER _____ [ ] PATIENT REQUEST

This information is made at the request of the patient or personal representative. YES NO
If no, please explain: _____
Is this authorization limited to a Single Disclosure/Exchange? YES NO IF NO AUTHORIZATION WILL EXPIRE IN ONE YEAR
This information may be disclosed/exchanged effective: IMMEDIATELY OTHER (specify date) _____
This authorization [ ] DOES or [ ] DOES NOT extend to information placed in my record after the date I signed this form.
Is there any information you do not want to release? NO YES (specify)_____

As the person signing this authorization, I acknowledge that I am giving permission to Clinch River Health Services to disclose/exchange PHI. I further acknowledge that:

- I may refuse to sign this authorization.
- Clinch River Health Services will not condition treatment on my signing the authorization.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, by notifying the providing organization in writing. There is a potential for any information disclosed/exchanges pursuant to this authorization to be subject to redisclosure by the recipient and, there, no longer protected by the provisions of the HIPAA Privacy Rule.
- If this information is being disclosed/exchanged from records protected by the Federal Substance Abuse confidentiality rules (42 CFR, Part 2), the Federal rules prohibit the recipient from making any further disclosure/exchange of this information unless further disclosure is expressly permitted by my written authorization or as otherwise permitted by 42 CFR Part 2. A general authorization for this disclosure/release of medical or other information is NOT sufficient for this purpose.
- This information will be shared with those individuals in the criminal justice system who have a need for the information in connection with their duty to monitor my treatment.
- I understand that under Virginia statute I may pay a reasonable cost-based fee that includes the cost of supplies and labor, or postage, there is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

PATIENT SIGNATURE:	DATE:
PARENT/GUARDIAN SIGNATURE:	DATE:

The patient or authorized representative was given a copy of this authorization or may request a copy at any time.