Clinch River Health Services Authorization for Use/Disclosure of Protected Health Information

Full Laged Name:													
IAuthorize Clinch River Health Services	T						l cen	T					
Telephone # (276) 467-2201 Fax # (276) 467-2673 Please Eax to this # only Telephone # (276) 467-2201 Fax # (276) 467-2673 Please Eax to this # only To disclose information to ADDR Name of Agency/Exchange Info: To reache information from: Address: Telephone # Percent Percent Description of information requested for disclosure/exchange: Progress Note History and Physical Substance Abuse Info Assessments	DOB:	Г				-	SSN:						
Telephone \$ (276) 467-2201 Fex # (276) 467-2673 Please £ex to this # only Order disclose Name of Agency/Exchange Info: Name of Name of Info: Name of	I Authorize :												
Telephone # 1	Address: 1763		3 Vete	rans	Memorial	Hwy	Suite	101	Dung				
Information to: Name of Agency/Facility To Receive/Exchange Info: Address: Add	Telephone # (27		467-220	1			Fax#	(:	276) 467				
To receive Address:	Information to:												
Description of information requested for disclosure/exchange: Lab Results	☐ To receive												
Crisis Stabilization							Fax#						
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Medical Information			0.750.01111.7										
Psychiatric Information Other (list)		y and Physical					242.5						
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DisGNOSIS AND/OR TREATMENT OF HIV/AIDS REQUIRES ADDITIONAL AUTHORIZATION. WITH MY SIGNATURE/DATE, HERE. / IAM ALSO AUTHORIZING THE RELEASE OF THIS INFORMATION. At the request of patient or personal representative? Yes No (if no, please explain) As the person signing this authorization, I acknowledge that I am giving permission to CRHS to disclose/exchange protected health Information. I further acknowledge that: I may refuse to sign this authorization. Clinch River Health Services will not condition treatment on my signing of this authorization. Clinch River Health Services will not condition treatment on my signing of this authorization. Clinch River Health Services will not condition 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 re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPPA 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 in 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. Postage is an additional charge. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment. It is there say information that you do sot													
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