Authorization to Release Confidential Information

517 W. Grace Street Richmond, VA 23220
Medical Records- phone: (804) 804-783-2505 x1779; fax: (804) 649-1635

Patient's Full Name: ____ **Date of Birth**: ______________________________

I hereby authorize Daily Planet Health Services to (check one or both): □ **Release to** □ **Request from**
Individual or Organization:
Name ____Phone: ____________________Fax:______________________
Address: ____
Person or Provider Requesting Information: ____

The following information and records: (check all that apply):

□ Part of Record (specify below) □ Laboratory Result(s) □ Entire Record □ Immunization Record

□ Mental Health Information (specify below) □ HIV, AIDS □ Oral Health Information □ Other (Specify below)

Additional Detail: ____
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□ Substance Use Information *(disclosure must be limited to that information which is necessary to carry out the stated purpose*):
□ All Substance Use (SUD) records
□ Only this SUD information (MUST provide explicit description): ____
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Dates of Service: ________________________________

This information is being used/disclosed for the following purpose (check all the apply):
□ Coordinate Continuing Care □ Insurance/Payment □ Legal □ At request of Individual

□ Disability Determination □ Workers Compensation □ Other; specify below:

Additional Detail:____
____

Authorization to Release Information:
1. I understand that I am giving my permission to the health care entity named above for disclosure of confidential health records. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made will be included in my health record.
2. Only the information needed to satisfy the stated purpose of this disclosure will be shared. I understand this will include information added after the authorization origination date and up to the authorization expiration date.
3. I understand that the confidentiality of medical and billing information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that information, other than Drug and Alcohol treatment records, disclosed with my permission may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rule.
4. I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon my signing this authorization.
5. I understand that I may revoke this consent at any time in writing, and that that revocation will not apply to information that has already been released base on this authorization. This authorization will expire in 365 days, unless I provide an earlier expiration date below.
6. I understand that drug and alcohol treatment records are protected by federal confidentiality rules (42 CFR Part 2) and prohibit the recipient from making any further disclosure of this information unless with written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rule restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

____ ______________________________
Signature of Client or Authorized Representative Date Signed

____ ______________________________
Name and description of representative's authority, if applicable Expiration Date of Consent