AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

NAME: _____BIRTHDATE: ___/___/____

ADDRESS: _____

___ I hereby authorize _____ to disclose medical information to _____ for the purpose of treatment planning and referral.

___ I hereby authorize _____ to disclose medical information to _____ for the purpose of treatment planning and referral.

___ I hereby authorize _____ to disclose _____ to _____ for the purpose of _____.

___ I hereby authorize _____ to disclose information gathered at intake and additional services provided to _____ for the purpose of treatment planning and referral.

___ I hereby authorize _____ to disclose information gathered at intake and additional services provided to _____ for the purpose of treatment planning and referral.

___ I hereby authorize _____ to disclose information gathered at intake and additional services provided to patient requested community resources for the purpose of treatment planning and referral.

___ I hereby authorize _____ to disclose _____ _____ to _____ for the purpose of _____.

Phone: 662.325.2001
P.O. Box 6189
Miss State, MS 39762

This authorization shall remain in effect until _____ (date) or until _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below.

INITIAL ON THE THREE SPACES BELOW:

I understand that the records to be disclosed pursuant to this authorization may contain:

___ records relating to participation in any federally assisted drug and abuse program;

___ information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately (unless this authorization pertains specifically to psychotherapy notes);

___ information relating to HIV testing, HIV status, or AIDS.

I understand that such information is subject to special protections pursuant to state and federal laws and regulations. I understand this confidential information may be shared with all members of the Vision Rehabilitation Services team (VRS) that provide direct service to me or only provide professional advice to those who are providing direct service.

The purpose of sharing this information is to provide the best opportunity for optimal treatment planning and referral. All members privy to this information are required to keep this information confidential in accordance with the law. By my initials, I authorize the disclosure of records containing such information if they are otherwise included within the scope of authorization. I understand that I am not obligated to disclose this

information to _____ to engage in services for which I qualify. I have the right to limit the release of this information to individuals that I choose, unless there is an exception that qualifies for unauthorized disclosure as stated in the Notice of Privacy Practices.

I understand that all parties listed above will receive a copy of this group authorization form unless I state otherwise. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I may request a copy of the signed authorization or revoke this authorization at any time (except to the extent that action has been take in reliance upon it) by submitting a written and signed notification to my case manager _____ at _____.

_____ **Patient Signature**

_____ **Patient Representative Signature**

_____ **Printed Name**

_____ **Printed Name and relationship**

_____ **Date**

_____ **Staff Name**

RELEASE OF INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, children, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to any family member or others you must sign this form.

I authorize _____ to release my medical and/or billing information to the following individuals:

_____ Relation to Patient _____

_____ Relation to Patient _____

_____ Relation to Patient _____

This release of information will remain in effect until terminated by me in writing.

MESSAGES

Please call: ( ) home _____ ( ) cell _____
( ) work _____ ( ) other _____

If unable to reach me personally by phone:

( ) you may leave a detailed message
( ) please leave a message simply asking for me to return your call
( ) you may leave a message with other family member or friend (please list):
Name _____ Phone _____

Name _____ Phone _____

Please send email: ( ) _____

_____ _____
Patient Signature Date

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www.oib-tac.org