

DBHDS AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Hiram W. Davis Medical Center
 Attention: HIM
 PO Box 4030
 Petersburg, VA 23803

Telephone Number: (804) 524-7420

Fax: (844) 523-7721

Patient Name:	
DOB:	SS# <i>(optional)</i>

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Social Work Assessment |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Lab Work | <input type="checkbox"/> Consultations | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> HIV/AIDS Information | <input type="checkbox"/> Substance Abuse Information | <input type="checkbox"/> Psychological Evaluation |
| <input type="checkbox"/> Other:: | | |

Specified purpose or need for use/disclosure is: <input type="checkbox"/> Diagnosis/Treatment <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Other, Specify: Personal	
Permission is hereby given to:	Hiram W Davis Medical Center; HIM Director or his authorized designee
To disclose information to: _____ <small style="display: block; text-align: center; margin-left: 100px;">(Name, title and organization)</small> <small style="display: block; text-align: center; margin-left: 250px;">Street Address, City, State, Zip</small> <small style="display: block; text-align: right; margin-right: 50px;">Phone/Fax #</small>	
I also authorize the recipient to use the information received pursuant to this authorization.	

As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person/class of persons to disclose and use protected health information. I further acknowledge that:

- I may refuse to sign this authorization.
- DBHDS/ Hiram W. Davis Medical Center cannot condition the provision of treatment to me on my signing of this authorization.
- The original or a copy of this authorization shall be included with my original records.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records.
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed 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 of this information unless further disclosure is expressly permitted by your written authorization 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 rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

If not previously revoked, this authorization will expire in:	<input type="checkbox"/> 90 Days	<input type="checkbox"/> One Year	<input type="checkbox"/> On <i>(specify date or event)</i>
The information may be disclosed effective:	<input type="checkbox"/> Immediately	<input type="checkbox"/> <i>(specify date)</i>	
This authorization <input type="checkbox"/> does <input type="checkbox"/> does not extend to information placed in my record after the date I signed this form.			

Signature of Individual (adult) or Legally Authorized Representative	Relationship	Date Signed
Signature of Minor (if required by law)		Date Signed
Witness (optional)		Date Signed

