AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient/Inmate Name	Date of Birth	Social Security Number

Patient/Inmate ID Number

THIS INFORMATION IS TO BE DISCLOSED TO:

Attention:
Address:
City, State Zip:

THIS INFORMATION IS TO BE DISCLOSED BY:

Name of Entity:
Attention:
Address of Entity:
City, State Zip:

REASON FOR REQUESTED INFORMATION:

TO BE READ AND SIGNED BY PATIENT/INMATE

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This document authorizes physicians, administrators, records custodians, and all medical personnel to furnish full and complete medical reports and information hereby requested, to the recipient listed above.
2. This authorization includes but is not limited to, all hospital and medical records, writings, charts, notes, reports of operations, admission summaries, discharge summaries, consultations, nurses notes, medications, letters, documents, reports, x-ray reports, laboratory reports or results, any tests or test results, any rehabilitation and/or physical therapy records, and/or any other written material contained in your file, in your possession or under your control which relates to the care and treatment of the patient named above. You are specifically authorized to photocopy the following records:

_____ Entire Medical Record, as described in number 2 above
_____ Only the following:
- _____ Current Medications
- _____ Lab Results
- _____ Progress Notes of Current Treatment
- _____ Discharge Summary

From Date: _____ To Date: _____ (if none indicated, include any and all time periods)

3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but that if I do, it will not have any effect on any actions the organization took before receiving the revocation.
4. I understand that the information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
5. I understand that signing this authorization is voluntary. My treatment or payment will not be conditioned upon my authorization of this disclosure.
6. I understand that this authorization will expire upon my release from custody.
7. A reproduced copy of this authorization shall be as valid as the original.
8. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I check the box below. In the event the health information described above includes any of these types of information, and I check the box below, I specifically authorize release of such information to recipient. Recipient is prohibited from redisclosing such information without my authorization unless permitted or required to do so under state and/or federal law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.

- _____ Alcohol/Drug Treatment
- _____ Mental Health Information
- _____ HIV-Related Information

In addition, I understand that if I have questions regarding NaphCare's privacy policies I may direct them to NaphCare, Inc., Attn: Privacy Officer, 2090 Columbiana Road, Suite 4000, Birmingham, AL 35216.

_____ _____

Signature of patient/inmate or representative authorized by law Date