Preferred Family Healthcare

Clarity Healthcare

Authorization to Release Protected Health Information

(Instructions on Page 2)

1. CLIENT INFORMATION

Client Name *(First, Middle, Last)*	Date of Birth *(mm-dd-yyy)*	☐ Check this box if client is deceased.
Client Address *(Street, City, State, ZIP Code)*		

2. RELEASE INFORMATION

☐ Personal ☐ Legal ☐ Continuity of Care ☐ Other:

3. WHO DO YOU WANT TO RELEASE YOUR INFORMATION?

Check one box and complete if applicable.

☐ **Preferred Family Healthcare, Inc and its affiliates (Dayspring/Clarity)**

☐ **Other,** specify organization, department, or individual

_____

Street _____

City _____

State _____ ZIP Code _____

Phone _____ Fax _____

4. WHO DO YOU WANT TO RECEIVE YOUR INFORMATION?

Check one box and complete if applicable.

☐ **Myself**

☐ **Legal Guardian:** _____

☐ **Other,** specify organization, department, or individual

_____

Street _____

City _____

State _____ ZIP Code _____

Phone _____ Fax _____

Unless otherwise revoked, this authorization will expire on the following date: _____
If left blank, this authorization will expire 1 year from the date signed.

5. DELIVERY OF INFORMATION

☐ US Mail (address listed above)

☐ FAX (number listed above)

☐ Electronic via secure email (list email address): _____

☐ Pick-up at a PFH Location (please specify location): _____

☐ Other, specify: _____

6. RECORDS TO BE RELEASED

Timeframe to Be Released

FROM _____ *(mm-dd-yyyy)* TO _____ *(mm-dd-yyyy)*

Type of Records/Information (check all that apply)

☐ Complete Record
☐ Assessments
☐ Progress Notes
☐ Progress Toward Goals
☐ Psychological Evaluations
☐ Treatment Plans/Treatment Plan Updates
☐ Diagnoses
☐ Lab Results
☐ Medication List
☐ Immunization Record
☐ Employment Verification
☐ Education Records: Grades, Attendance, Behavior, Vocational Information
☐ Acknowledgment of Admission and/or Program Participation
☐ Dates of Treatment/Discharge Summary

☐ Other: _____

☐ I authorize the release of any of the above marked items that contain information regarding treatment for Alcohol and Substance Abuse, which may include urine drug screening and drug test results.

☐ I authorize the release of any of the above records which may indicate the presence of communicable, non-communicable, or venereal diseases, including but not limited to hepatitis, syphilis, gonorrhea, HIV or AIDS.

Other, specify if applicable _____

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7. SIGNATURE AND DATE *The client or legal representative must sign and date this authorization.*

- This authorization may be revoked at any time by executing an electronic written revocation or by providing written notice of revocation to Preferred Family Healthcare at Fax: 660-677-4005 or medicalrecords@pfh.org, except to the extent that the agency has already taken action in reliance on it.
- I understand the information to be released includes behavioral and/or mental health care records and could include records related to HIV/AIDS, communicable diseases and/or treatment for alcohol or substance use disorder.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.
- Federal law/42 CFR Part 2 prohibits the unauthorized re-disclosure of alcohol and substance use disorder treatment records.

Note: A client (18 years or older) must authorize the release of their own information unless incapacitated or deceased. If signing for a minor client, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Client Signature (required) ▶	**Print Name**	**Date** *(mm-dd-yyyy)*
Guardian Signature ▶	**Print Name**	**Date** *(mm-dd-yyyy)*

Relationship to Client

☐ Biological/Adoptive Parent ☐ Legal Guardian ☐ Legal Authorized Representative

NOTE: If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

FOR ILLINOIS ONLY: Witness Signature (required)	**Date** (required) *(mm-dd-yyyy)*

INSTRUCTIONS: When picking up copies in person, a photo ID will be required as well as a copy of any legal documentation verifying legal right to request such information.

1. Section 1: Type or write client name, date of birth and address. Check box if client is deceased.
2. Section 2: Indicate the reason information is being requested. For client access to your own records, check personal.
3. Section 3: Indicate who you are requesting information **FROM**.
4. Section 4: Indicate who you want the information released **TO.** If the client is a minor, list Legal Guardian's name and address.
5. Expiration date: Provide an expiration date. If no date is provided the authorization will expire 1 (one) year from the date it is signed.
6. Section 5: Indicate how you want to receive the information.
7. Section 6:
    a. Enter the date range of records you are requesting. If you do not know the exact dates the month and year will be accepted. (Example: May 2002 - September 2003). If you wish to release a series of visits extending into the future, you may enter the option of "past, present, and future."
    b. Mark the type of records requested. If "Complete record is checked" the following shall be produced for the designated time period if present in the record: History and Physical examinations and reports; medication list, preadmission screening, progress notes, treatment plan and treatment plan updates, prescriptions and Physician orders, Vital Signs, Transitions/aftercare plan, Discharge Summary, Case management records, Referrals, Comprehensive Assessment and Psychiatric Evaluation, Diagnostic Tests and Lab results. You may limit the amount of information provided by only checking the corresponding boxes of the information needed or specifically specifying in the "Other" box.
    c. Records related to alcohol or substance use disorder treatment, HIV/AIDS, and/or communicable disease must be specifically authorized. Mark these boxes if your desire is to authorize the release of these records/information.
8. Section 7: Read disclosures, sign and date authorization. If signed by someone other than the client, include legal documentation, print full name and indicate relationship to client.
9. Please contact the ROI department at the address or phone number listed below if you have questions or concerns. Due to the high volume of phone calls, please allow 1-2 business days for a response. We appreciate your patience and look forward to serving you.

Preferred Family Healthcare, Inc
833-763-0418 | Fax: 660-677-4005 | medicalrecords@pfh.org

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