MERIDELL ACHIEVEMENT CENTER

Patient Label

AUTHORIZATION FOR USE & DISCLOSURE (RELEASE OR REQUEST) OF PROTECTED HEALTH INFORMATION

This form will authorize Meridell Achievement Center (MAC) to use and disclose or request certain health information about the person named below. All items must be completed and the authorization signed to be valid. I understand this authorization is voluntary, I may refuse to sign this authorization and I understand that MAC may not withhold treatment because I refuse to sign this authorization.

1. I authorize MAC to disclose or request health information, as described below, from the medical record of:

   Patient's Name: _____ Date of Birth: _____

2. The information specified below may be released to or requested from:

   Name/Agency: _____ Telephone: _____

   Address: _____ Email: _____

   City: _____ State: _____ Zip: _____ Fax: _____

3. The specific purpose(s) for this disclosure is/are (check ✓ your selection): ____ my personal records; ____ sharing with other healthcare providers as needed; ____ other (please describe) _____

4. SPECIFY EXACT INFORMATION TO BE RELEASED: (1) Place a check (✓) next to the specific information needed, (2) List the dates of treatment.

✓	INFORMATION	DATES OF SERVICE	✓	INFORMATION	DATES OF SERVICE
	Psychiatric Evaluation			Physician's Orders	
	Psychosocial History			Treatment Plans	
	Psychological Testing			Progress Notes	
	History and Physical			QEEG Report	
	Current Medications			Verbal Exchange of Information	
	Laboratory Report			Other:	
	Discharge Summary			Other:	
	Consultation Reports			Other:	

I acknowledge the following statements:

- This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Records disclosed are protected by Federal confidentially rules (42 CFR Part 2). Federal rules prohibit making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulation and may be redisclosed.
- I understand that I may revoke this authorization at any time by notifying MAC in writing at ATTN: MAC Health Information, of my intent to revoke this authorization, except that if I do notify MAC in writing of my intent to revoke this authorization, such revocation will not have any effect on any actions by MAC taken before the revocation.
- Unless otherwise revoked, I understand this authorization will expire 180 DAYS from the date this form is signed.
- I understand that general medical /psychiatric records sometimes contain references to drug/alcohol use, communicable or sexually transmitted diseases as well as AIDS (Acquired Immune Deficiency Syndrome) and HIV (Human Immunodeficiency Virus) test results.
- I understand I will be charged for any copies of my medical record or my child's medical record that I request. I understand fees for copies are due and payable before copies are released.
- I understand that I may be asked to show proof that I have the authority to sign an authorization to review and/or receive copies of the above named patient's medical record which I am requesting.
- I agree that a facsimile or photocopy of this authorization is as valid as the original.

_____ _____
Parent / Guardian Signature / Patient's Signature (if 18 or older) Relationship to Patient

_____ _____
Parent/Guardian or Patient (if 18 or older) Name - Please Print Date

_____ _____
Witness Signature Date