

**MERIDELL ACHIEVEMENT CENTER  
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Maiden/Prior Names: \_\_\_\_\_ Current Phone #: \_\_\_\_\_

Current Address: \_\_\_\_\_ Last 4 of SS#: \_\_\_\_\_

**To be released to or requested from:**

Self (address above)

\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Agency/Organization Telephone Number Street Address

\_\_\_\_\_  
Name / Attention to Fax Number City State Zip Code

Via (only when released to):  Mail  Fax  Pick-up  Verbal Exchange of Information ~~ONLY~~

**I am requesting disclosure of my protected health information for the following purpose:**

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Child Custody     | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Academic        | <input type="checkbox"/> Legal Investigation      | <input type="checkbox"/> Billing/Insurance | <input type="checkbox"/> Other: _____ |

**Dates of Service Requested:** \_\_\_\_\_

- I authorize the release of the following information **INCLUDING** all records that include any substance use disorder and/or substance use disorder treatment records.
- I authorize the release of the following information **EXCLUDING** all records that include any substance use disorder and/or substance use disorder treatment records.

**Only the information and records indicated below (check all that apply and /or specific if "Other" is checked):**

- |   |  |
|---|--|
| <input type="checkbox"/> Continuity/Transition of Care Packet | <input type="checkbox"/> Progress Notes                              |
| <input type="checkbox"/> Psychiatric Evaluation               | <input type="checkbox"/> Physician Orders                            |
| <input type="checkbox"/> History and Physical                 | <input type="checkbox"/> Lab/Diagnostic Reports                      |
| <input type="checkbox"/> Discharge Summary                    | <input type="checkbox"/> HIV Test Results and AIDS Treatment Records |
|   | <input type="checkbox"/> Other: _____                                |

This authorization will expire on \_\_\_\_/\_\_\_\_/20\_\_\_\_. (If not indicated, authorization will expire **ONE YEAR** from signature date)

**This form must be completed in full before signing:**

\_\_\_\_\_  
Signature of Legal Guardian or Patient (if 18 or older) Printed Name of Person Signing Form Relationship to Patient

\_\_\_\_\_  
Witness Signature/Credentials Date Signed

This authorization is intended to allow **MERIDELL ACHIEVEMENT CENTER** to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. 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. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (**42 CFR, Part 2**) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. It is your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

\_\_\_\_\_  
Revocation Signature Date/Time