 Authorization

To Use and Disclose Protected Health Information (PHI)

**ALL** fields are required to be completed

Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOMELESS

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alliance House follows federal and state confidentiality regulations prohibiting release of information about you without your permission or as otherwise permitted or required by law. Substance Abuse Disorder (SUD) treatment records have additional privacy protections (42 CGR Part 2) I understand that use and disclosure means sharing of my medical records including verbal, written and electronic communications. I give permission for Alliance House and the person/organization listed below to share my medical, mental health, behavioral health, and/or substance abuse treatment records. Alliance House does not re-disclose PHI received from 3rd party providers, entities, and/or agencies, except where required by law. Signing this form is voluntary and not required for membership at Alliance House. I understand I may revoke this authorization at any time. To revoke this authorization, I will complete and submit Alliance House’s written revocation form. Revocation will not include any information already shared in reliance upon this authorization. I understand that any disclosure of this information has the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse (SUD) Patient Records, 42, C.F.R. Part 2 that re-disclosure is prohibited, and the health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

\*ACCESS TO MY RECORD: I understand I can request a copy of my record. My provider(s) will review my request and the request can be denied if the records are found to be detrimental to myself, my treatment or others.

**NAME OF THE AGENCY REQUESTING: Alliance House Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1724 South Main St. Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Salt Lake City, UT 84115**

**(801)486-5012 FX: (801)466-5077**

**NAME OF THE AGENCY OR PERSON AUTHORIZED to RELEASE/DISCLOSE:**

Agency/Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Probation  Legal/Court  Employment | Coordination of Care  School  Benefits & Eligibility/Coordination |

**PURPOSE**

**EXIPIRATION**

|  |  |
| --- | --- |
| 1x disclosure  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (specific timeframe) | End of or inactive membership at Alliance House |