INSTRUCTIONS – Authorization to Release/Obtain Information Form

This form is used to release your protected health information as required by federal and state privacy laws. This form is used for you or your Personal Representative to authorize View Point Health to release or request your protected health information from another person or organization at your request.

Each section of the form must be completed; missing information will result in delays in processing the authorization.

Section A: Use or Disclosure of Health Information

This section is how you would like View Point Health to communicate with the Organization/Individual you are authorizing.

COMMUNICATION OPTIONS
• Check **Release Information To:** View Point Health will release your health information. • Check **Obtain Information From:** View Point Health will request your health information. • Check both **Release Information To** and **Obtain Information From**: View Point Health and the Organization/Individual can exchange your information.

Section B: Scope and Use of Disclosure

You must indicate or describe the information to be released. **Check ONLY ONE box that best describes your request.**

The first choice is **All Mental Health, IDD, Medical (Info. Concerning the testing for Human Immune Virus and/or treatment for Acquired Immune Deficiency Syndrome and any related conditions), and/or substance use disorder information.** If you check this box, View Point Health may release all information related to your treatment or services. If someone is directly involved in coordinating your health care or benefits, you may want them to have access to all of your information.

The second choice is **Specific health information.** By checking this box, you indicate that you want only specific information to be released. Describe the specific information on the line provided.

Section C: Purpose of Use or Disclosure

This section is regarding why your Health Information is being released or requested.

Section D: Expiration (When this Authorization will end)

Print either an expiration date OR event, **but not both.** If an expiration event is used, the event must relate to the purpose of the release of information being authorized. For example, an Authorization may expire "one year from the date the Authorization is signed," or "upon termination of enrollment in the health plan."

An Authorization remains valid until its expiration date or event, unless effectively revoked in writing by the individual before that date or event.

Section E: Other Information of Importance

You or your Personal Representative must sign the authorization.
If you are the Personal Representative, the client's signature is not required. However, you must provide the requested information, signature and date. A copy of the legal authority, such as a Durable Power of Attorney for Healthcare or other legal document, must be on file at View Point Health or be submitted with this form.

A witness must sign the authorization. Your witness can be a View Point Health Employee or someone not related to you.

VIEW POINT Health
A Total Care Perspective

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION FORM

Client Name	
Date of Birth	
Social Security Number	
Client ID	

Section A: Use or Disclosure of Health Information

By signing this form, I authorize the use and/or disclosure of my individually-identifiable health information maintained by View Point Health.

Communication: ☐ **Release Information To** ☐ **Obtain Information From**

Organization and/or Individual Name	
Address	
City/State/Zip	
Phone	**Fax**
Email	

Section B: Scope and Use of Disclosure

Information that may be used or disclosed based on this authorization is as follows **(ONLY CHECK ONE)**:

☐ All Mental Health, IDD, Medical (Info. Concerning the testing for Human Immune Virus and/or treatment for Acquired Immune Deficiency Syndrome and any related conditions), and/or substance use disorder information.

☐ Specific health information including mental, medical (info. concerning the testing for HIV and/or treatment of AIDS and any related conditions), and/or substance use disorder information **(List information being released):**

_____

Section C: Purpose of Use or Disclosure

The purpose for this disclosure is **(ONLY CHECK ONE)**:

☐ Specifically, the following purpose: **Select a commonly used purpose or type the purpose**

☐ I choose not disclose the purpose. *(This box may **NOT** be checked if the information to be disclosed pertains to substance use information)*

Section D: Expiration: If an expiration event is used, the event must relate to the client or the purpose for the disclosure.

Date (MM/DD/YYYY) or Event _____

Section E: Other Information of Importance

1. I understand that View Point Health cannot guarantee that the recipient of this information will not re-disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consist of treatment information about a client in a substance use disorder program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the client or as otherwise permitted by federal law governing confidentiality of substance use disorder patient records (42 CFR, Part 2).
2. I understand that, except when I am receiving healthcare solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from View Point Health.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by View Point Health in reliance on this authorization before written notice of revocation is received (See Notice of Privacy Practices).

Signature of Client Or Legally Authorized Representative	Printed Name of Client or Legally Authorized Representative	Date	Time AM☐ PM☐

Signature of Witness	Title/Relationship to Client	Date	Time AM☐ PM☐

RESET PRINT