AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A: This section must be completed for all Authorizations

Patient Last Name: _____	**Patient First Name:** _____	**Patient Date of Birth:** _____
Phone: _____	**Email:** _____	
Address: _____		
City: _____	**State:** _____	**Zip:** _____
ERC Pathlight Treatment Location/Facility: _____	**ERC Pathlight Date(s) of Treatment:** _____	
Purpose of Disclosure (*e.g., at patient's request*)**:** _____		

I hereby authorize Eating Recovery Center / Pathlight Mood & Anxiety Center to (*please check at least one*):

☐ **Exchange with** (*e.g., provider-to-provider*)

☐ **Release to** (*e.g., a family member or attorney*)

☐ **Obtain from** (*e.g., requesting records from another provider*)

Recipient Name: _____	**Relationship to Patient:** _____	
Phone: _____	**Email:** _____	
Address: _____		
City: _____	**State:** _____	**Zip:** _____

I hereby authorize the use or disclosure of following health information:

☐ **Complete Health Record**

**Note: Records related to the following require specific authorization to be released:*

- ☐ Substance Abuse Treatment
- ☐ STD/HIV/AIDS
- ☐ Sexual Assault Reports or Testing
- ☐ Genetic Testing
- ☐ Mental Health and/or Psychiatric Conditions

☐ **ONLY the Following Health Records (*check all that apply*):**

- ☐ Progress Notes
- ☐ Nutrition/Dietary
- ☐ Nursing/Medical Information
- ☐ Educational Progress
- ☐ Treatment Plans
- ☐ Labs/Test Results/Orders
- ☐ Discharge/Aftercare Plan
- ☐ Medications
- ☐ Billing Records
- ☐ Service Date(s)
- ☐ Assessment(s)

☐ **Other:** _____

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Section B: The method in which you would like records delivered

☐ **Encrypted Email**
Recipient's Email Address: _____

☐ **Unencrypted Email**
Recipient's Email Address: _____

☐ **Flash Drive to the Recipient's Address Listed Above** (*software to unencrypt may be required*)

☐ **Fax** (*requested information must be under 50 pages*)
Recipient's Fax Number: _____

☐ **Paper – via Mail to the Recipient's Address Listed Above**

Section C: Expiration and Revocation

If the health information to be disclosed contains HIV/AIDS or substance abuse treatment records, this Authorization expires within sixty (60) days.
Otherwise, you may select either of the following expiration events:

☐ 1 year from the date in which I, or my legal representative, signs this Authorization.

☐ Upon the happening of the following event (*e.g., "Upon release of the above records*"):

_____

I understand that:

1. I may revoke this Authorization at any time by providing written revocation to ERC Pathlight. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.
2. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
3. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.
4. I have the right to inspect or copy the health information to be used or disclosed pursuant to this Authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Name (printed): _____

Patient Signature: _____ **Date**: _____

Representative/Guardian Name (printed):_____

Representative/Guardian Signature: _____ **Date**: _____

Relationship to Patient:

☐ Parent/Legal Guardian
☐ Power of Attorney
☐ Executor or Personal Representative
☐ Surrogate Decision-Maker
☐ Other: _____