East House
moving lives forward

## Authorization to Release / Obtain Health Information

***(Please PRINT)***

**CLIENT'S LAST NAME:** **FIRST:** **M.I:**

**DATE OF BIRTH:**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

I understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations (alcohol and drug abuse), New York State Mental Hygiene Law Section 33.13 (mental health treatment), confidential HIV* related information, and the Privacy Rule of the Health Insurance Portability and Accountability ACT of 1998 (HIPAA) 45 C.F.R. Parts 160 and 164, and that re-disclosure of this information without my additional written authorization is prohibited. Any information I authorize other agencies to release to this facility will be held strictly confidential and will not be released without my permission.

If I am authorizing the release of alcohol or drug treatment, mental health treatment, or HIV-related information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

I have the right to cancel/refuse the release of the above information at any time by writing to East House at the address provided at the top of this page. I understand that I may cancel/refuse this release of information except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

☐ ***I authorize East House to share my health care information with the following recipient / provider:***

☐ ***I authorize East House to request my health information from:***

**NAME(s):**_____

**ADDRESS:**_____

_____

**The following information can be shared / requested (*check all that apply*):**

☐ Intake/Screening Assessment
☐ Current Treatment/Service Plan
☐ Attendance & Progress Reports
☐ Discharge Summary
☐ Legal Information
☐ Financial / Benefit Information
☐ Medical/Dental/Lab Reports
☐ Psychiatric/Psychological Evaluation
☐ Psychosocial Summary
☐ Vocational Rehabilitation Report
☐ School/Training Performance Report
☐ Employment Performance Report
☐ Other_____
*(Must specify)*

**For the purpose(s) (*check all that apply*):**

- ☐ Evaluation for Services
- ☐ Coordination of Professional Services
- ☐ Obtain/Retain Insurance/Financial Benefits
- ☐ Education/Training/Employment Assistance
- ☐ Disability Determination
- ☐ Legal Assistance
- ☐ Education/Support/Coordination of Services with Family/Concerned Other
- ☐ Housing Assistance
- ☐ Other _____
  *(Must specify)*

**This consent is valid for the following period (*indicate one of the following*):**

☐ I hereby authorize the **one-time release** of the above information to the person/organization/ facility/program identified above. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

☐ I hereby authorize the **periodic release** of the above information to the person/organization/ facility/program identified above **as often as necessary to plan for/provide care and treatment. I understand that this consent is in effect until I cancel my permission to release information or until 3 months after discharge from an East House program.** I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

**REVOCATION: (Only to be used if / when a client revokes consent)**

Client Signature:_____ Date: _____