# AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **I Understand that:**

**1**.This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH** T**REATMENT**, expect psychotherapy notes, and **CONFIDENTAL HIV RELATED INFORMATION** only if I check the appropriate boxes on line in item 9(a). In the event the health information described below includes any of these types of information, and check the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

**2.** If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing 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.

**3.** I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand I may revoke this authorization except to the extent that action has already been taken based on this authorization.

**4.** 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.

**5**. Information disclosed under this authorization might be redisclosed by the recipient (expect as noted above in item 2, and this redisclosure may no longer be protected by federal of state law.

**6.** THIS AUTHORIZATION DOES NOT AUTHROIZE YOU TO DISCRUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE PATIENT ADVOCATE SPECIFIED IN ITEM 9(b).

**7.** Name and Address of health provider or entity to release this information:

**8.** Please release information to **Joe Valente** my Patient Advocate with Team Uncle Joe and the PATCH Network 20907 Kings Clover Court, Humble, Tx 77346. Phone 530-591-2890 joev@teamunclejoe.org

**9(a). Specific information to be release:**

☐ **Medical Record from** (date) _____ to _____

☐ **Entire Medical Record**, *including patient histories, office notes (except physiotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.*

☐ **Other:**_____

**Include:** ☐ **Alcohol/Drug Treatment** ☐ **Mental Health Information** ☐ **HIV-Related Information**

**9(b). Authorization to Discuss Health Information**

By initialing here _____ I authorize_____

*Initials* *Name of Individual Healthcare Provider*

To discuss my health information with my patient advocate **Joe Valente** with Team Uncle Joe and the PATCH Network - 20907 Kings Clover Court, Humble, Tx 77346. Phone 530-591-2890 joev@teamunclejoe.org

10. Reason for release of Information: ◉ *At Request of Individual* ○ *Other:* _____

11. Date or event on which this authorization will expire: _____

12. If not the patient name of person signing the form: _____

13. Authority to sign on behalf of patient: _____

_____ _____

*Signature of patient or representative authorized by Law* *Date*