LIFEWORKS NW

ROIA _____

EFFC. DATE_____

Authorization to Use and Disclose Protected Health Information

Unless revoked, this authorization will remain in effect agency-wide and program-wide for the duration of my treatment and thirty days after discharge for coordination of care or until: _____

First and Last Name: _____ Date of Birth: _____

1. Person/Organization to disclose information to _____

   Phone: _____ FAX: _____ Address: _____

2. Information will be used on my behalf to both release and receive information for the following purposes:

   ☐ Evaluation Review ☐ Treatment referral

   ☐ Coordination of Care ☐ All of above

   ☐ Treatment planning

   In accordance with HIPAA 42CFR, please list any specific information you would like to disclose _____

3. By **initialing** the spaces below, I authorize the release of the following protected medical records:

   ► _____ Disclose alcohol and drug information
   Initial here

   ► _____ Disclose mental health and/or medication information
   Initial here

   ► _____ Disclose HIV/AIDS information
   Initial here

4. Federal or state law requires that HIV/AIDS, mental health, drug/alcohol, or genetic testing information not be re-disclosed. I understand that this information may be shared via phone, fax, mail, email, in written form, or in person. I understand that I may revoke (i.e., take back) this authorization either in writing or verbally at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described on this form. If LifeWorks NW has already used or disclosed information because of this authorization, that cannot be undone. This information has been disclosed from Lifeworks NW whose confidentiality is protected by federal law. Federal regulation (42 CFR, Part 2) prohibits you from further disclosing it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Signature of client or guardian Date of signature

_____ _____

Relationship to the client if signed by guardian Reason client is unable to sign.