

Patient MRN _____

Patient DOB _____



604 Rose Ave.
Venice, CA 90291
(310) 392-8636
FAX (310) 392-7875

Authorization for Release of Health Information

I, _____,
[patient's name]

authorize **The SUMMIT Program at Venice Family Clinic**
[name or general designation of individual or entity making the disclosure]

to disclose **All substance use disorder treatment and records**
[describe how much and what kind of information may be disclosed]

to **All departments and programs at Venice Family Clinic**
[name of entity with a treating provider relationship who will receive the information]

for the purpose of **Coordination of Care**
[describe the purpose of the disclosure; as specific as possible]

Scope of Disclosure:

- | | |
|---|---|
| <input type="checkbox"/> Drug test results | <input checked="" type="checkbox"/> Case management/care coordination |
| <input type="checkbox"/> Laboratory test results | <input checked="" type="checkbox"/> Substance Use Disorder records |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Primary Care records |
| <input type="checkbox"/> HIV/AIDS test information | <input type="checkbox"/> Mental Health records |
| <input checked="" type="checkbox"/> Other (specify): <u>All Substance Use Disorder Treatment and Records</u> | |

I understand that substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without written consent of the patient unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

Until the patient no longer receives medical or substance use services at VFC_____.

[Specify a date or condition this form expires]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____

Signature of Patient

Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____

Date revoked: _____

Staff name: _____