Authorization for Release of Protected Health Information (PHI)

NEW DIRECTIONS®

All sections must be completed for this authorization to be valid. A copy of this authorization form will be available to you, but you should retain a copy for your records.

1. THIS AUTHORIZATION ALLOWS THE FOLLOWING MEMBER'S INFORMATION TO BE RELEASED TO NEW DIRECTIONS BEHAVIORAL HEALTH:

Print Name Of Member

Member Date of Birth

Member Health Plan I.D. Number (if applicable)

Member Address

Member Primary Phone Number

Member Secondary Phone Number

2. PURPOSE OF RELEASE IS:

3. INFORMATION TO BE RELEASED (Please check only one box)

☐ All medical records for services provided by any physician or hospital. (INCLUDING alcohol and substance use or abuse information).

☐ All Medical records for services provided by any physician or hospital (EXCLUDING alcohol and substance use or abuse information).

☐ Only specific information:

4. RELEASE INFORMATION PERTAINING TO THIS TIME PERIOD (Please check only one box)

☐ Any and all dates, including future dates until expiration of authorization

☐ From MM/DD/YYYY to MM/DD/YYYY

5. EXPIRATION OF AUTHORIZATION

Valid for one (1) year unless otherwise specified or revoked.

6. PATIENT AUTHORIZATION

I understand that:

- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
- I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

If signing authorization as Power of Attorney, Power of Attorney for Health Care, or Guardian/Conservator, a copy of the legal document MUST ACCOMPANY this form.

7. SIGNATURE

(Member, Guardian, or Authorized Representative)

Date (MM/DD/YYYY)

Relationship of Authorized Representative to Member

Minor Signature (Signature of Minor Where Required)

Date (MM/DD/YYYY)

Substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of 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. Parts 160 and 164, and cannot be disclosed without written consent unless otherwise provided for by the regulations.