AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Zumbro Valley Health Center

INSTRUCTIONS TO CLIENT OR THEIR PERSONAL REPRESENTATIVE: 1. Make sure all fields on this form are filled in.
2. Sign and date this form only if you believe the use and disclosure of information is in your best interest.

CLIENT NAME: ____ ______________

Last First M.I. Date of Birth

Other name(s) under which personal health information (PHI) may be logged: ______________________

I hereby authorize: **Zumbro Valley Health Center, 343 Wood Lake Drive SE, Rochester, MN 55904 Phone: 507-289-2089**

To: ☐ **Disclose to** ☐ **Exchange with** ☐ **Obtain from**

Facility Name & Phone Number: ______________________________________

Other Individual's Name & Phone Number: ______________________________

Email: ______________________

Encrypted? ☐ Yes ☐ No – Selecting "no" means the information being sent could be visible to others and is not secure

Valid Time for ROI: ☐ **For this specific time period: Start Date:** ____________ **End Date:** ____________
☐ **One Year** ☐ **Unlimited Time** (this ROI will not expire unless otherwise revoked by myself)

Valid Time Period for Records Being Requested: From Date: _________ **To Date:** _________
If no specific date(s) are provided, only the most recent document(s) will be released for items that are checked.

Specifically Requesting: The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released.

☐ **Chemical Dependency Program** ☐ **Psychotherapy Notes**

Mental Health, Chemical Dependency or Other Health Information Including the Following:

- ☐ **Diagnostic Assessment/Comprehensive Evaluation**
- ☐ **Psychological/Psychiatric Evaluation**
- ☐ **Medication History**
- ☐ **CD Nursing Assessment**
- ☐ **Admission Information**
- ☐ **Functional Assessment**
- ☐ **Crisis Risk Assessment/Intervention Plan**
- ☐ **Primary Care Provider Notes**
- ☐ **Other** (please specify): ____________________
- ☐ **Lab Results**
- ☐ **Chemical Dependency Program**
- ☐ **Discharge/Treatment Summary**
- ☐ **Medication Management Notes**
- ☐ **Treatment Plan**
- ☐ **Progress Notes**
- ☐ **LOCUS**
- ☐ **Legal Documents**

For the Following Purpose:

- ☐ **Determination of Disability**
- ☐ **Social Services Involvement**
- ☐ **At the Request of the Client**
- ☐ **Emergency Contact**
- ☐ **Other** (please specify): ______________________________
- ☐ **Coordination of Care**
- ☐ **Court Ordered**
- ☐ **Continuing Care/Treatment Planning**
- ☐ **Billing**

Private Health Information (PHI) includes both written and oral Information. Do you give your permission for the facility or Individual to speak with ZVHC staff: ■ **YES** ☐ **NO**

Wisconsin Privacy Regulations: ☐ I understand that the client may also have a copy of the records requested above

- I understand that I have the right to revoke this authorization. If Zumbro Valley Health Center has already released information based on this consent, we cannot retrieve what has already been released.
- I recognize that the protected health information used or disclosed according to this authorization may be re-disclosed by the recipient and ZVHC can no longer protect it.
- I understand that the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, and HIV/AIDS.
- I understand that I will not be denied services by ZVHC or its providers based on whether or not I sign this authorization.

______________________ ____________ ______________________________

Client Signature **Date (Required)** **Parent, Guardian, or Authorized Signature & Relationship to Client**