Frequently Asked Questions regarding the Authorization For Release of Protected Health Information

I have numbered the sections on the authorization form to assist you with the completion of this form. We are not emailing records. Please give a mailing address or a pickup date and time. We can fax reports but not entire medical records.

1. #1 This section is all six lines from patient name to last four of social security number. Please complete entire section.

2. #2 If the records are for yourself, please check the "self' box. Please use section 5 to inform us how you would like to receive your records. Provide fax number or pick up date. Continue with #8 to complete the form.

3. #3 If records are for Physician Office, Insurance, Disability, Attorney. Please provide telephone number and street address also in this area.

4. #4 Name/Attention to also Fax number, City, State, and Zip Code.

5. #5 Please check box of how records are to be processed. Mail, Fax, Pick up.

6. #6 This is for any other individual you would like to have your records released to. Please complete all lines.

7. #7 Again, this is how we are releasing them to that specific individual. Please check appropriate box.

8. #8 This is the purpose of the disclosure of your protected health information. Please select all that apply or select other and give purpose.

9. #9 Dates of Service. If you do not remember month and year, please.

10. #10 Please only select one of the boxes. The top box includes substance use diagnosis and treatment records. Box two does not.

11. #11 Please check the information indicated that you would like sent. If you do not select, we will not be able to send anything.

12. #12 Date authorization will expire. If you do not put a date, the authorization will expire in 1 year.

13. #13 Please review the form before you sign.

14. #14 Please date the form.

15. DO NOT SIGN THIS LINE UNLESS YOU ARE REVOKING THIS AUTHORIZATION!

We hope this helped you with completion of this form.

Thank you!

Wekiva Springs, LLC

3947 Salisbury Road, Jacksonville, FL 32216

Phone# 904 296 3533 ext. 3027 (Copy Service) • Medical Records Department Fax #'s: 904 899 8752 or 904 899 7999

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. Patient Name: _____ Birth Date: _____

Maiden/Prior Names: _____ Current Phone#: _____

Current Address: _____ Last4 of SS#: _____

To be released to or requested from:

2. ❑ Self (address above)

3. ❑ _____ (____) _____ _____

Agency/Organization | Telephone Number | Street Address

4. _____ (___) _____ _____

Name / Attention to | Fax Number | City State Zip Code

5. **Via (only when released to):** ❑ Mail ❑ Fax ❑ Pick-up ONLY ❑ Email: _____

❑ Verbal Exchange of Information ONLY

6. ❑ _____ (____) _____ _____

Name (Any other recipient to receive these records i.e., family member) | Telephone Number | Street Address

_____

City State Zip Code

7. **Via (only when released to):** ❑ Mail ❑ Fax ❑ Pick-up ONLY ❑ Email: _____

❑ Verbal Exchange of Information ONLY

8. I am requesting disclosure of my protected health information for the following purpose:

❑ Continuing Care ❑ Disability Determination ❑ Child Custody ❑ Academic

❑ Legal Investigation ❑ Billing/Insurance ❑ Personal Use ❑ Other: _____

9. Dates of Service Requested: _____

10. ❑ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

❑ **I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

11. Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

❑ Continuity/Transition of Care Packet ❑ Physician Orders ❑ Psychiatric Evaluation

❑ Lab/Diagnostic Reports ❑ History and Physical ❑ HIV Test Results and AIDS Treatment Records

❑ Discharge Summary ❑ Progress Notes ❑ Other: _____

12. This authorization will expire on ___/___/20 ____ . (If not indicated, authorization will expire <u>one year</u> from signature date)

This form must be completed in full before signing:

13. _____ _____ _____

Patient's signature (required for ages 18 and older) | Parent Legal Guardian signature (if applicable) | Relationship to Patient

_____ **14.** _____

Witness signature/Credentials | Date Signed

This authorization is intended to allow (facility name) to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

DO NOT SIGN THIS LINE UNLESS YOU ARE REVOKING THIS AUTHORIZATION!

15. _____ _____

Revocation Signature | Date/Time