Evergreen Treatment Services

CLINIC SERVICES | REACH

Transforming the lives of individuals and their communities through innovative and effective addiction and social services.

Authorization for Release of Protected Health Information

Request Date: _____ Patient ID: _____

Patient Name: _____ DOB: _____

I, _____ (patient / authorized representative name), hereby authorize Evergreen Treatment Services (ETS) to disclose my protected health information to _____ (person /organization info can be shared with).

Reason for Disclosure:

☐ Care Continuity ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

My records should be sent to:

☐ Email: _____ ☐ Fax: _____

☐ Mailing Address: _____

Please indicate which documents / information you are requesting from your medical record:

- ☐ Medical Reports
- ☐ Case Management
- ☐ Urine / BAL Test Results
- ☐ Drug & Alcohol History
- ☐ Assessment of Treatment Progress
- ☐ Group Participation
- ☐ HIV / AIDS Information
- ☐ Social Security Number & Date of Birth
- ☐ Lab Reports
- ☐ Attendance at Agency Appointments
- ☐ Psychiatric Assessment & Treatments
- ☐ Treatment Modality & Plan
- ☐ STD Information
- ☐ Other: _____

This authorization will automatically expire in 90 days from the date of signature unless an earlier date, event, or specific condition is written below:

Specify alternative expiration: _____

My consent and authorization to this mutual disclosure and exchange of information is being granted with the following understandings:

I understand that I may revoke or modify this authorization at any time by submitting a written request to ETS, except to the extent that information may have already been disclosed pursuant to this consent and authorization.

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 understand that my treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accounting Act (45 CFR §160 & 164) and cannot be redisclosed without my written consent, unless otherwise provided for in the regulations.

I have a right to receive a copy of this authorization: ☐ Copy Offered & Declined ☐ Copy Given

Patient Signature _____ Date _____

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please provide the following information:

Authorized Representative Signature _____ Date _____

Representative's Legal Authority (e.g., Guardian, Power of Attorney) _____

Please submit completed request forms to a member of your care team or email a copy to our Health Information Mangement team (HIM) at HIM@evergreentreatment.org. For more information, visit evergreentreatment.org/medical-records-requests.