Healthcare for the Homeless
Community Action Partnership

Authorization for Use and/or Disclosure of Protected Health Information (PHI)

Last Name ____ First Name ____ M.I ____ Date of Birth ____

Street Address ____ City ____ State ____ Zip Code ____

Home Phone ____ Work Phone ____

I hereby request and authorize: **Health Care for the Homeless** **1514 E 12th St. Ste. 201** **Phone: (307) 235-6116** **Fax: (307) 235-0249**	To **release** my information to: To **receive** my information from: *Marking both boxes indicates your authorization for* **Two Way Communication** *between the identified people/facilities* Person/Facility Name: ____ Address: ____ ____ Phone: ____ Fax: ____

Date of service(s):____ to ____ □ All Dates

The Protected Health Information to be released/received:

Entire Record	Medical History	Hospital Reports	Treatment Plans
Referral Information	Imaging Orders & Results	Lab Orders & Results	Social History
Medications	Immunization Records	Prenatal Records	Other:

I specifically authorize the release of Protected Health Information related to:

Substance abuse (including alcohol/drug abuse & treatment)
HIV related information (including testing, diagnosis, & treatment)
Mental Health (including psychotherapy notes)

Signature of Patient or Legal Guardian ____ Date ____

This Information is requested for the following purpose:

Coordination of Care	Continuation of Medical Care	Referral
Personal Use	Legal Purposes	Other:

My Rights

I understand I do not have to sign this authorization in order to get health care treatment, and if I do not sign, it will not affect the quality of care I receive at Health Care for the Homeless. I understand I may revoke this authorization at any time in writing and I understand revocation will not apply to information that has already been released. Once the office discloses Protected Health Information, the person/organization that receives it may re-disclose it and privacy laws may no longer protect it.

This authorization is effective now and will remain in effect until ____________ (date) or one year from date of signature, whichever is sooner.

Signature of Patient or Legal Guardian ____ Date ____ Signature of Witness ____ Date ____