Optum

Authorization for Release of Protected Health Information ("PHI")

New Perspectives of Oregon, on behalf of itself and affiliated companies, will use this form to obtain your written consent to disclose your PHI to the recipient of your choice. This request does not allow the recipient to make any of your treatment or direct care decisions. Please complete this form to consent to the release of your PHI, to the designated individual or organization, named in **Section 2** below. When filling out this form, provide your most current information.

Please return this completed form to:

OBC Medical Records Department

ATT: OBC Medical Records Coordinator

495 N. Keller Rd. Suite 200, Maitland, FL 32751

Fax: (833) 972- 0745

1) Patient Information (please provide current information)

Last Name	First Name	Middle Initial

Mailing Street Address	Apt. #

City	State	Zip

Date of Birth (mm / dd / yyyy)	Phone Number with Area Code

2) Individual or Organization Authorized to Receive Information

I authorize New Perspectives of Oregon to disclose my PHI to the individual or organization designated below. I understand that there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my designated individual is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by them without my permission.

Individual/Organization Name	Relationship to Patient

Mailing Street Address	Unit/Suite #

City	State	Zip

Phone Number with Area Code	Fax Number with Area Code

3) Purpose and Delivery Method of Disclosure

I authorize the above-mentioned facility to release my information for the following reason(s):

- ☐ Coordination of Care
- ☐ Insurance
- ☐ Legal
- ☐ Personal Use
- ☐ Other _____

I authorize the above-mentioned facility to release my information via the following delivery method (please select one):

- ☐ Pick-up In Person
- ☐ USPS Mail
- ☐ Fax
- ☐ Secure Email (provide email address below)

Email Address: _____

4) Description of Information to be Disclosed

I authorize the following records to be disclosed:

☐ **ALL** Mental/Behavioral Health Records

If not **ALL**, please select one (or more) of the following record types:

- ☐ Attendance
- ☐ Assessments
- ☐ Billing Record
- ☐ Consultations
- ☐ Discharge Summary
- ☐ Lab Results
- ☐ Medications/Dosing
- ☐ Provider Orders
- ☐ Toxicology Results
- ☐ Treatment Plan
- ☐ Other: _____

The following items require special consent by law.
Check the boxes below to indicate your intent to include:

- ☐ Alcohol or Substance Use
- ☐ Genetic Information
- ☐ HIV/AIDS
- ☐ Reproductive Health Care Services
- ☐ Psychotherapy Notes

I understand that my 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 my written consent unless otherwise provided for by the regulations.

Please indicate in the space below the date(s) of service, for the above selected records, that you would like released (If this section is left blank, all dates of service for the above selected records will be included**):**

5) Expiration and Revocation

I understand that this consent will expire thirty-six (36) months from the date of my signature as noted below unless I revoke in writing, request a different date, or am a resident of a state that requires a shorter timeframe.
I wish for my consent to expire on a different date, noted here: _____

For those residing in the states below, the expiration date cannot exceed:

12 Months: MD, MN **24 Months**: MT, VA, Puerto Rico **30 Months**: ME

I further understand that I may revoke this authorization at any time by notifying, in writing, the facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

6) Signature(s)

A. Patient: I have read and understand the above information. I acknowledge that by signing this form, I understand that my decision of whether or not to sign this form will not affect my eligibility for treatment or payment and am voluntarily giving consent to above-mentioned facility to disclose my PHI to the individual or organization designated in **Section 2**.

_____ _____
Signature of Patient **Date**

B. Personal or Legal Representative of Patient: I have read and understand the request and acknowledge that by signing this form I have the legal authority to act on behalf of the patient, and I am attaching the appropriate supporting documentation to this request.

_____ _____
Printed Name of Representative **Relationship to Patient**

_____ _____
Signature of Representative **Date**

Please return this completed form to one of the methods indicated at the beginning of this document, and please keep a copy for your own records.