AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Information. ***Please PRINT legibly. All sections of this form must be completed.***

First Name: 1 Last Name: 2 M.I.: 3

Phone Number: 4 Date of Birth: 5

I, as Client / Legal Guardian, authorize *ReDiscover* to:

6

Disclose to:	**Obtain from:**
☐ Designated Recipient *(specify below)*	☐ Designated Recipient *(specify below)*
☐ Any entity or person in treating provider relationship with client	☐ Any entity or person in treating provider relationship with client
☐ Health Information Exchange and participants in treating provider relationship with client	☐ Health Information Exchange and participants in treating provider relationship with client

7 **For the purpose of:** ☐ Personal Use ☐ Continuation of Care ☐ Legal ☐ Insurance ☐ Other, specify:

8 **This authorization applies to all applicable health information:**

☐ Including substance use disorder information ☐ Excluding substance use disorder information

Designated Recipient Information:

Name / Organization: 9

Address: 10
Street Address City State Zip Code

Phone Number: 11 Fax Number: 12

Relationship to Client: 13 E-Mail: 14

This Authorization becomes effective upon signing and will expire on 15 *(define date or event)*

If left blank, this Authorization will automatically expire one year after the date signed.

Except to the extent that health information has already been disclosed or obtained, I have the right to revoke this Authorization at any time by submitting my revocation in writing to ***ReDiscover***, 1555 NE Rice Rd., Lee's Summit, MO 64086, Attn: Privacy Officer.

I may refuse to sign this Authorization and such refusal will not affect my / the client's ability to obtain treatment unless otherwise prohibited.

Upon a written request to ***ReDiscover*** at the address above, I may request a List of Disclosures to which my / the client's health information has been disclosed within the last two (2) years of the request.

16
Client / Legal Guardian Signature

17
Date

18
Client / Legal Guardian Printed Name

19
If other than Client, relationship to Client

For office use only:	**SCANNING STAMP HERE**	**MR #:**

ReDiscover
1555 NE Rice Road * Lee's Summit, MO 64086 * (816) 966-0900 * Fax (816) 347-3200

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION –

USER GUIDE

Purpose: For client / legal guardian to authorize disclosure of protected health information to other parties.

Directions: Follow each numbered blank to complete the form.

1. Client's first name.
2. Client's last name.
3. Client's middle initial (if applicable).
4. Client's best phone number.
5. Client's date of birth. Please include month, date, and year.
6. Check all applicable boxes you are allowing ***ReDiscover*** to **Disclose to** and/or **Obtain from**
   - **Designated Recipient** is any person or organization (i.e. family, friend, attorney, etc.)
   - **Any entity or person in treating provider relationship with client** is every professional entity or person that is involved in your treatment (i.e. primary care physician, other mental health or substance use treatment providers, hospital, residential, etc.)
   - **Health Information Exchange and participants in treating provider relationship with client** is every HIE organization(s) that ***ReDiscover*** is a part of to share information for treatment and coordination purposes
7. Check **ONE** box to specify why you are giving authorization to disclose to or obtain from.
8. Check **ONE** box to specify if you will allow ***ReDiscover*** to share your applicable substance use disorder (SUD) information or not. ***ReDiscover*** is a community health center that provides both mental health and SUD services.
9. Recipient's full name or name of the organization.
10. Recipient's street address, city, state, and zip code.
11. Recipient's phone number.
12. Recipient's fax number.
13. Recipient's relationship to the client.
14. Recipient's E-Mail address.
15. Define the date or event this authorization will expire on. If this is left blank, the authorization will expire one year after the signed date.
16. Signature of the client or legal guardian who can authorize this request.
17. Date of the signature.
18. Print the name of the signer on #17.
19. If client is not the signer, specify the signer's relationship to the client.

Please visit www.rediscovermh.org/client-resources/office-visit-forms/ for FAQ on Requesting Medical Records.

ReDiscover
1555 NE Rice Road * Lee's Summit, MO 64086 * (816) 966-0900 * Fax (816) 347-3200