**AVITA COMMUNITY PARTNERS**
**RELEASE OF INFORMATION**
**AUTHORIZATION T0 USE AND DISCLOSE HEALTH INFORMATION**

## Section A: Use or Disclosure of Health Information

By signing this Authorization below in "Section E", I authorize the use or disclosure of my individually-identifiable health information maintained by Avita Community Partners. My health information may be disclosed under this Authorization to the following recipient:

Print name (person and/or organization): ______________________________

Street 1: ______________________________

Street 2: ______________________________

Apartment/Suite #__________City:______________________State:____________________Postal Code: ____________

County:______________________________Country: ______________________________

## Section B: Scope and Use of Disclosure

**Health information that may be used or disclosed through this Authorization includes but is not limited to:**

- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
- Information concerning Human Immune Virus testing and/or treatment for Acquired Immune Deficiency Syndrome and any related conditions
- Privileged communications between me and a psychiatrist, psychologist, licensed clinical social worker, licensed marriage and family counselor, or licensed professional counselor, or between them concerning my communications with any of them.

☐ All of the above health Information about me, including my clinical records created/received by the person or organization above
☐ All health information about me as described in the preceding checkbox, excluding the following (specify below):
☐ Specific health information including only (specify below):

______________________________

______________________________

## Section C. Purpose of Use or Disclosure - The purpose for this Authorization is (are):

☐ The client has initiated the request for information to be used or disclosed and the client does not elect to disclose its purpose. **Note:** THIS BOX MAY NOT BE CHECKED if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.

☐ Specifically, the following purpose(s): ______________________________

______________________________

## Section D: Authorization Expiration: Expiration Date:______________________OR

Expiration Event: ______________________________

**Note:** Expiration date may not exceed twelve (12) months from date of signing. If an expiration event is used, the event must relate to the client or the purpose for the use or disclosure.

## Section E. Authorization Signature(s) & Other Information of Importance

I have read and understood the **Other Information of Importance** (specified on page 2) associated with this Authorization, and have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature:______________________________Date ____________________

Client's printed name:______________________________Date of birth (mm/dd/yy):____________SSN:________________

Parent/legal guardian or representative signature (if applicable):______________________________Date ____________

Printed name:______________________________Relationship to client: ______________________________

**WITNESS -** By signing below as witness, I am certifying that I know the person and/or persons signing this form or am satisfied of the identity of the person and/or persons signing this form.

Witness signature______________________________Title/Relationship______________________Date __________

Printed name of witness:______________________________Phone number of witness: (______)____________________

Address of witness (☐Check if address is same as entered in "Section A" above.):

Street address:______________________________City:______________________State:_______Zip: ________

## REVOCATION

I hereby revoke this Authorization. I understand this revocation becomes effective on date signed below. I further understand that this revocation will not have any effect on any action taken by Avita in reliance on this authorization before the date revocation is received.

Client's signature:______________________________Date ___________

Parent/legal guardian signature (if applicable):______________________________Date____________

Printed name of parent/guardian:______________________________Relationship to client: ______________________

☐Revocation request by mail (date received): Staff signature: Title:

## AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

**Other Information of Importance:**

1. I understand that Avita Community Partners (Avita) cannot guarantee that the recipient of this information will not re-disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally assisted alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2).
2. I understand that, except when I am (1) receiving research related treatment or (2) receiving health care solely for creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Avita.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by this agency in reliance on this Authorization before written notice of revocation is received by this agency. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at Avita.
4. The ROI shall be completed in the presence of and signed by a Avita staff member as witness, or by a Notary Public when not completed in the presence of an Avita staff member.

**Guidance:** Questions regarding Avita's policies and procedures for "Use & Disclosure of Client Service Records" may be directed to Avita's Privacy Officer at 678-513-5700 or 1-800-525-8751.