AVITA COMMUNITY PARTNERS
RELEASE OF INFORMATION AUTHORIZATION TO
USE AND DISCLOSE HEALTH INFORMATION AND PRIVILEGED COMMUNICATIONS

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 and it agents. My health information may be disclosed under this Authorization to the following recipient:

Print name (person and/or organization): _____

☐ Check box if for your treating providers, health plans, third party payers and people helping to operate this program.

Street: _____

Apartment/Suite #_____ City: _____ State:_____ Postal Code:_____ County:_____

Country: _____ Phone Number:_____ Email Address: _____

Section B: Scope and Use of Disclosure

Information I am requesting to be released:

☐ All of my health information, including my clinical records, both created and/or received by the person or organization above.

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

- Substance Use Disorder (SUD) information pertaining to the identity of the patient, medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items; diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date for a SUD maintained by a federally-assisted alcohol or drug abuse program or federally-assisted SUD program; or;
- Information concerning Human Immune Virus testing and/or treatment for Acquired Immune Deficiency Syndrome and any related conditions;
- This authorization includes 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 and including SUD counseling notes being notes recorded (in any medium) by a part 2 program provider who is a SUD or mental health professional documenting or analyzing the contents of conversation during a private SUD counseling session or a group, joint, or family SUD counseling session and that are separated from the rest of the patient's SUD and medical record.

☐ 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: _____

Section F: 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

Section G: Other Information of Importance:

1. I understand 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 if the recipient is an intermediary and/or a covered entity or business associate for purposes of treatment, payment, or health care operations that my record (or information contained in the record) may be redisclosed in accordance with the permissions contained in HIPAA regulations, except for uses and disclosures for civil, criminal, administrative and legislative proceedings against me.
3. 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 release of information and that my refusal to sign will not affect my ability to obtain treatment from Avita.
4. I understand I may revoke this release of information verbally or 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 release of information before verbal or written notice of revocation is received by this agency.
5. The release of information shall be completed in the presence of and signed by an Avita staff member as witness or provide a copy of government issued ID (i.e. driver's license) when not completed in the presence of an Avita staff member.
6. I understand if this consent for release of information is for treatment, payment, or health care operations by or for Avita or another provider, that the records have the potential for redisclosure by the recipient and would no longer be protected by 42 CFR, Part 2.

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