PUREVIEW Health Center

**GENERAL AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

Patient Name: ____________________________________________________________ Date of Birth______________

Mailing Address: ____________________________________________ City_______________ State____ Zip________

**I AUTHORIZE THE PUREVIEW HEALTH CENTER TO RELEASE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING PEOPLE:**

___________________________________ ___________________________________

___________________________________ ___________________________________

I understand that the person(s) and/or organization(s) listed above are not health care providers, health plans or other covered entities who must follow the federal privacy standards, the health information disclosed as a result of the authorization may no longer be protected by the federal privacy standards and it is possible that they may redisclose my health information without my authorization.

**I REQUEST THE FOLLOWING *RESTRICTIONS* WITH RESPECT TO THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION:**

Restricted___________________________________ Restricted___________________________________

**The below records will be released unless checked:**

___Alcohol and Drug Info/Treatment ____Psychiatric/Behavioral Health ___AIDS/HIV/STD Testing and Results

**Confidentiality of Alcohol and Drug Abuse Patient Records**: Any records disclosed by PureView pursuant to your consent granted by this General Authorization will contain a notice to the receiving party about further disclosure of the records in one of the following formats: 1) *This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFRT part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)5 and 2.65;* OR 2) *42 CFR part 2 prohibits unauthorized disclosure of these records.*

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION**

To inspect or copy the health information to be used or disclosed; to receive a copy of this authorization; to refuse to sign this authorization; withdraw this authorization.

Start Date:_____________________________________ End Date:_______________________________
Today's date. Example: (01/01/21) Any future date. Example: (01/01/22)

Patient Signature:_________________________________________________________________ Date:______________