Cooperative Health

Authorization for Release of Health Information

A. Patient Information

Patient Name (Last, First, MI): _____ Date of Birth: _____

Address: _____ Medical Record Number: _____

City / State / ZIP: _____ Phone Number: _____

B. Type of Authorization

☐ I authorize COOPERATIVE HEALTH to **DISCLOSE** (release) information to the party named in Section C.

☐ I authorize the party named in Section C to disclose information to COOPERATIVE HEALTH (**REQUEST** / obtain records).

☐ I am requesting a **COPY OF MY OWN RECORDS** from COOPERATIVE HEALTH. *(Section C may be left blank.)*

C. Provider / Entity Information

Name, address, phone, and fax of the person or organization COOPERATIVE HEALTH will disclose to or request from:

Name: _____

Address: _____

Phone: _____ Fax: _____

D. Information to Be Released

☐ History & Physical ☐ Progress Notes ☐ Consultation Reports

☐ Laboratory Results ☐ Radiology Reports ☐ Discharge Summary

☐ Immunization Records ☐ Medication List ☐ Billing / Financial Records

☐ Entire Medical Record

☐ Other (describe): _____

Date Range — From: _____ Date Range — To: _____

E. Specially Protected Information — Initials Required

The categories below receive heightened confidentiality protection under federal and/or state law. Checking "Entire Medical Record" in Section D does **NOT** release any of these categories. To release a category, you must **ALSO** check and initial that line below.

☐ **Substance use disorder (SUD) records** *protected by 42 CFR Part 2* Initials: _____

☐ **Mental health records** *does not include psychotherapy notes* Initials: _____

☐ **HIV / AIDS-related information and test results** Initials: _____

☐ **Genetic testing results** Initials: _____

Not released by this form

Federal law requires separate authorization or consent for the following notes. A psychotherapy notes authorization may be combined only with another psychotherapy notes authorization; an SUD counseling notes consent may be combined only with another SUD counseling notes consent.

- **Psychotherapy notes** — use the Authorization for Release of Psychotherapy Notes
- **SUD counseling notes** — use the Consent for Disclosure of SUD Counseling Notes

If you initialed "SUD records" above

- This is a consent for the specific disclosure described on this form.
- Records disclosed under this consent may not be re-disclosed by the recipient except as permitted by 42 CFR Part 2. Each disclosure will include this notice: *"42 CFR part 2 prohibits unauthorized use or disclosure of these records."*
- This form does not permit your SUD records, or testimony about them, to be used in any civil, criminal, administrative, or legislative proceeding against you. That requires a separate written consent or a court order that meets Part 2 requirements.
- Initialing "SUD records" does not release SUD counseling notes (see the Consent for Disclosure of SUD Counseling Notes).

F. Purpose of Disclosure

☐ Continuing Care / Treatment ☐ Transfer of Care ☐ Insurance / Payment

☐ At My Request (personal use) ☐ Disability / Government Benefit ☐ Legal Proceeding*

☐ Other (describe): _____

**Legal Proceeding may not be selected for SUD records. A separate consent or qualifying court order is required.*

G. Expiration

This authorization expires on the date or event below. Please write a specific date or event. If none is specified, this authorization expires one (1) year from the date signed.

Expiration Date: OR Expiration Event:

H. Your Rights and Our Responsibilities

- **Signing is voluntary.** COOPERATIVE HEALTH will not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign, except where treatment is provided solely to create information for a third party. If you do not sign, the information will not be released.
- **You may revoke this authorization in writing at any time,** except to the extent COOPERATIVE HEALTH or another party has already acted in reliance on it. Send a written revocation to compliance@cooperativehealth.org or deliver it to the front desk at any Cooperative Health location.
- **Re-disclosure.** Once information is disclosed, the recipient may re-disclose it and it may no longer be protected by the HIPAA Privacy Rule. SUD records protected by 42 CFR Part 2 remain subject to the restrictions described in Section E. Any further use or disclosure must also comply with applicable state law.
- **You will receive a copy** of this signed authorization.
- Information disclosed for underwriting purposes, as applicable, may be subject to additional restrictions under state or federal law.

I. Signature

☐ Patient ☐ Parent / Guardian ☐ Personal Representative

If signing as a personal representative, describe your authority to act on the patient's behalf (e.g., healthcare power of attorney, legal guardian):

Description of Authority:

Signature: Date:

Printed Name: Relationship to Patient (if applicable):

Witness Signature (if required): Date:

Questions About This Form

Contact Cooperative Health's Privacy Officer at compliance@cooperativehealth.org or 803-733-5969 x4107.

This form is for internal and patient use in connection with Cooperative Health's compliance and privacy program and does not constitute legal advice.