**SCOTTSDALE RECOVERY CENTER**
Send Request via email or fax to: medicalrecords@scottsdalerecovery.com or (480)739-6116, ATTN: DORIS
Questions? Dial direct: (480) 699-9044

SCOTTSDALE RECOVERY
RECONNECT • REBUILD • RECOVER

# RELEASE OF HEALTH INFORMATION / SUBSTANCE USE DISORDER RECORDS

*HIPAA and 42 C.F.R. Part 2*

**Client name**:_____**Date of Birth**: _____/_____/_____
**Address**: _____
**Phone number**: _____

I authorize _____ *[insert name or description]* to disclose Client's health information to: _____*[insert name & relationship]* at _____*[address, if known]*; _____ *[email address, if known]*; _ *[phone number, if known]*; _____*[fax number, if known]*.

**Explicit description of the type of health information to be disclosed:**

_____ **MY ENTIRE MEDICAL RECORD, INCLUDING ALL MY SUBSTANCE USE DISORDER RECORDS.**

*If you would like less than the entire medical record released, please select the types of records that you want released:*

_____ Allergies and intolerances
_____ Assessment and plans of treatment
_____ Biopsychosocial
_____ Certificate of completion
_____ Clinical notes (such as progress notes)
_____ Discharge planning/summary
_____ Goals
_____ Health concerns
_____ History & Physical
_____ Immunizations
_____ Labs/imaging tests (such as, urinalysis)
_____ Medical Follow-Up Notes
_____ Medications
_____ Problems
_____ Progress/Presence in Treatment
_____ Psychiatric evaluations
_____ Psychiatric Follow-Up Notes
_____ Vital Signs

**How much of this health information may be disclosed:**

☐ **NO DATE RESTRICTIONS**
☐ Last 30 days
☐ Last 60 days
☐ Last 90 days
☐ Last 6 months
☐ Last Year
☐ Date range: ___/___/___ to ___/___/___

**Specific description of the purpose of the disclosure:** *please check all that apply*

____ Treatment, payment and normal health care operations
____ Social security benefits
____ Community organization assistance
____ Worker's compensation
____ Life / disability insurance
____ Parole/probation: _____ *[insert case number]*
____ Drug/criminal court: _____ *[insert case number]*
____ Abuse investigation: _____ *[insert case number]*
____ Other judicial, law enforcement or administrative proceedings: _____ *[insert case number]*
____ Other *(specify)*: _____

 **NOTICE TO RECIPIENT: 42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.**

**How do you want the information shared?** *(please check **all** that apply)*
☐ Mail/fax ☐ Email ☐ Phone ☐ Digital platform (such as Zoom)

_____ ***(please initial):*** *Depending on the circumstances, SRC may not be able to send electronic communications using a secure (encrypted) method of transmission. There are risks associated with unsecured communications that you should consider, such as the communication being intercepted or sent to the wrong person. By initialing this paragraph, you agree that you understand these risks and consent to SRC sending the Client's health information using an unsecure (unencrypted) method of communication.*

I understand that the information released will contain information about the Client's substance use disorder and may contain other sensitive information about the Client, such as information regarding communicable diseases (including sexually transmitted diseases and HIV/AIDS), genetic testing/genetic history, mental/behavioral health, and intellectual and developmental disabilities. I consent to the disclosure of this sensitive health information in connection with the release of the Client's substance use disorder records.

I understand that the provider will **not** condition treatment, payment for treatment, enrollment or eligibility for benefits on my signing this authorization form. I understand that I may refuse to sign this authorization form.

I understand that I may revoke (take back) this authorization at any time, except to the extent that someone has already acted in reliance on it. To revoke my authorization, I will submit a written request to the email or fax number listed at the top of page 1 of this form. Unless I revoke this authorization earlier, it will expire one year (365 days) from the date of the signature on this form.

***Criminal Justice System Disclosures:** If the disclosure is to individuals within the criminal justice system (such as probation/parole or a drug/criminal court), those individuals may require that this consent remain in effect until the final disposition of the Client's conditional release or case.*

I understand that, if this information is disclosed to a third party, the information may no longer be protected by the Health Information Portability and Accountability Act and its implementing regulations (collectively, "HIPAA"). However, my substance use disorder records will continue to be protected by 42 U.S.C. § 290dd-2 and its implementing regulations at 42 C.F.R. Part 2 (collectively, "Part 2").

I have been given a copy of this form.

_____ _____
Signature of Client Date

_____
Signature of Guardian (*if applicable*)

_____ _____
Signature of Witness Date