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 or persons signing this form or am satisfied of the identity of the person 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 the purpose of 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.

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.