STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*

FORM A – AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

Section I

First Name*	M.I.	Last Name*	Date of Birth*	Social Security Number

Address	City	State	Zip Code

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

Disclosing Entity* *(Covered Entity such as a health plan/insurer or provider)*

Address	Telephone Number

City	State	Zip Code

Recipient (Person or Entity) *

Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)*

Section III

Reason for Disclosure*

Health information to be disclosed*

Specify time period, if desired:
Release only information from the period _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event _____ *(mm/dd/yyyy)*

- I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

Signature of Individual*	Date* *(mm/dd/yyyy)*

Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	Date* *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual *(Personal representative shall submit proof of authority to the disclosing entity)*

☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other ☐ N/A

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic,)	Date Released

Instructions for Completing ODM 10221
STANDARD AUTHORIZATION FORM

This standard authorization form should be used by an individual or their personal representative to give consent to the release of personal health information. This form is not a patient access request under 45 CFR 164.524.

Which form do you use? If you are a Part 2 program (Substance Use Disorder (SUD) provider), or you are releasing records obtained from a Part 2 program, use FORM B. In all other cases, use FORM A. Form A does not need to be used when the exchange of information is for the purposes of treatment, payment and healthcare operations under HIPAA.

- Part 2 programs are federally assisted individuals or entities that hold themselves out as providing, and provide, substance use disorder diagnosis, treatment or treatment referral. For more information, see 42 CFR 2.11.

Section I (both FORM A and FORM B)

- Enter the requested information for the individual whose health information is to be released.
- Individuals are not required to provide a Social Security Number (SSN). If the SSN or additional identifying information is missing, an entity may not be able to identify the individual in order to respond to the request. An option is to provide the last 4 digits of the SSN.

Section II (Form A)

- "Disclosing Entity (Name of Covered Entity)" is the health plan/insurer or provider who has the individual's PHI which will be released. Enter the name of the Covered Entity as well as the contact information.
- "Recipient (Person or Entity)" - list the person or organization who should receive the PHI. Enter the contact information (phone number, email address, fax number, mailing address, etc.).

Section II (Form B)

- "Disclosing Entity (Name of Holder of Part 2 Program Information)" is the person or entity who has the individual's substance use disorder information to be released. Enter the name of the Holder of Part 2 Program information as well as the contact information. You may use a general description such as "any drug or alcohol treatment program that has provided services to the individual." More than one person or entity may be named.
- "The information is to be provided to the following" - list the person or organization who should receive the substance use disorder information. This can be an individual, a provider, a third party payer (health plan/insurer), or a non-treating entity, such as a health information exchange, a parole office, or a drug court program. More than one person or entity may be named.
- Use a separate FORM B for each person or organization that will be disclosing information.
- **If "Named Non-Treatment Provider (such as an intermediary or research entity)" is selected then a, b, and/or c must be completed too.** *The form is not complete if this box is checked and no additional information is provided in a, b, and/or c.*
    - A treatment provider relationship exists where an individual has agreed to or is required to be diagnosed, evaluated, or treated by, or to accept consultation from, an individual or entity who provides or agrees to provide the service. For more information, see 42 CFR 2.11.
- Enter the contact information (phone number, email address, fax number, mailing address, etc.).

Section III (both FORM A and FORM B):

- "Reason for Disclosure" must tell why the individual's information is being released.
- "Health Information to be disclosed" - must give a complete description of the information to be released. For Form B, please clearly specify the substance use disorder information that may be released.
- "Specify Time Period, if desired" is to be used, if necessary, to indicate a specific date range for the information to be disclosed (e.g. 7/1/2017 to 1/1/2018).

Section IV (both FORM A and FORM B)

- "Expiration Date or Event" is the specific date or event upon which the consent will expire. Event may be defined as the reason for the authorization or consent (e.g. insurance claim). If no date or event is provided, the authorization or consent will expire in one year.
- The individual whose information is being released should sign and date the form. If the individual is not able to sign the form, the personal representative should sign and date it. If a personal representative signs the form, indicate the relationship of the personal representative by selecting the appropriate box. Disclosing entity may require proof of authority of the representative.