AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

First Name: ________________ MI: ____ Last Name: __________________________ Date of Birth: _______________

Address: ____________________________________ Phone#: _____________e-mail: __________________________

I authorize copies of my health information sent:

From: ____ To: ____

Name of Organization	Name of Person or Organization
Address of Organization	Address of Organization
Phone # and/or e-mail	Phone # and/or e-mail

By means of:
___Patient Portal
___Electronic: encrypted e-mail: ____
___Fax: ____
___Paper (Pick up from or delivered to address): ____
___Other: ____
Hope Network does not have any control over the records released to an e-mail address once it leaves the Hope Network Server.

I authorize the release of the following information: Dates of Service __________________ to ________________

Evaluations and Assessments:

___Provider ___Physical Therapy ___Occupational Therapy ___Speech Therapy ___Social Work

Discharge Summaries:

___Provider ___Program ___Physical Therapy ___Occupational Therapy ___Speech Therapy

Other:

___Provider Notes ___Medication Review Notes ___Treatment Notes ___Social Work Notes

___Physical Therapy Notes ___Occupational Therapy Notes ___Speech Therapy Notes

___Vocational Therapy Notes ___Recreational Therapy Notes ___Treatment Plans ___ Medication List

___Records related to specific problem of: ____

___Other: ____

Provider includes: Physician, Psychiatry, Psychology, Psychosocial and Neuropsychological

I specifically authorize release of information related to the following that may be contained in the above disclosures, if applicable to me:

___Mental Health ___Substance Abuse Treatment ___HIV/AIDS

This form does not give consent to share psychotherapy notes.

Purpose of the Disclosure:

___Continuing Care ___Personal Use ___Insurance ___Legal/Attorney ___Disability ___Workers Compensation

___Other: ____

This authorization shall be in force and effect until:
___One year after Signature OR ___After specified event or condition: ____________________________.
If not specified this authorization will expire in 180 days from the date it was signed.

- ✓ I understand that I have the right to revoke this authorization in writing at any time by sending written notification to: Privacy Officer at 3075 Orchard Vista Drive SE, Grand Rapids, MI 49546 or email privacy@hopenetwork.org.
- ✓ I understand that a revocation may not be effective to prevent use and disclosure of information previously authorized or to stop action that has already been taken in reliance on this authorization.
- ✓ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Hope Network will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- ✓ Inspect or copy the protected health information to be used or disclosed as permitted under federal law or state law to the extent the state law provides greater access rights.
- ✓ Refuse to sign this authorization.
- ✓ Receive a copy of this authorization, containing my signature.

I have been made aware of Hope Network's Privacy Practices. The statements included in this authorization are binding on Hope Network.

____	____________________________
Signature of Consumer or Personal Representative	Date
____	____________________________
Printed Name of Consumer or Personal Representative	Basis of legal authority to act for Consumer