EastRidge Health Systems
235 S. Water Street • Martinsburg, West Virginia 25401

AUTHORIZATION TO RELEASE OR ACQUIRE PROTECTED HEALTH INFORMATION

1. _____
Client's Last name | First name | Middle initial | Date of birth | Social Security #

_____
Address: street | city | state | zip | Home phone | Work phone

2. **Authorization to Release or Acquire:** Regarding my health records, I authorize EastRidge Health Systems to:
□ Acquire □ Release

3. **I authorize my health records to be released to or acquired from the following agency:**

_____
Name and address of agency that will be receiving or providing information

4. **Health information to be released or acquired (please check items to be released or acquired):**

□ Acknowledgement of services	□ Diagnosis	□ Psychiatric Evaluation
□ Psychological Evaluation	□ Progress Notes	□ Treatment Plan
□ Service Summary	□ Intake Assessment	□ Discharge Summary
□ Medication Record	□ Other (specify) _____	

For the following dates of Service:_____

5. **Reason for disclosure:**

□ Further medical/mental health/substance abuse care	□ Insurance eligibility	□ Vocational rehab. evaluation
□ Payment of insurance claim	□ Legal investigation	□ Disability determination
□ At the request of the patient _____	□ Other (specify) _____	

6. **I understand that I can withdraw this consent at any time by submitting my request in writing to the above facility. This authorization is valid until _____ or 6 months from date signed if blank not filled in.**

I authorize release of my protected health information as specified above. I understand that my records may be protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and that my rights as a mental health patient are protected by WV Legislative Code 27-3-1, and cannot be disclosed without my written consent unless otherwise provided for in these regulations.

Prohibition of Redisclosure of Information: This information has been disclosed to you from records that may be protected by Federal confidentiality rules (42 CFR Part 2) and WV Legislative Code 27-3-1. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and WV Legislative Code 27-3-1. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have had the full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named above the protected health information described above.

7. **Signature**

_____
Signature of Client | Date

_____
Signature of Parent, Guardian, or legally authorized representative | Date | Relationship to client

_____
Witness | Date