SEQUEL
Youth & Family Services

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Phone Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in Box 9. In the event the health information described below includes any of these types of information, and I initial the line in Box 9, I specifically authorize release of such information to the person(s) or category of person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

7. Name and address of person(s) or category of person(s) to release this information:
Pomegranate Health Systems; 765 Pierce Drive, Columbus, OH 43223

8. Name and address of person(s) or category of person(s) to whom this information will be sent:

9 Specific information to be released:

- ☐ Medical Record from (insert date) __________________ to (insert date) ______________________
- ☐ Psychiatric Assessment and Psychiatric Progress Notes (except psychotherapy notes)
- ☐ History and Physical
- ☐ Most recent discharge summary and Master Treatment Plan
- ☐ Testing results (lab, x-ray, EEG, EKG, etc.)
- ☐ Records sent to you by other health care providers
- ☐ Physician orders and progress notes
- ☐ Billing records
- ☐ Verbal conversations with family members: (name person) ____
- ☐ Verbal conversations with non-family members: (name person) ____
- ☐ Court testimony and related services
- ☐ Other: _________________________________
____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. If I do not specify a date or event in this box, this authorization shall expire 24 months from the date of my signature below.
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient: (If applicable, attach supporting documentation).

I understand that after I sign this Authorization I may receive a copy. I also understand that I may inspect or copy the information to be used or disclosed, as provided for in 45 C.F.R. § 164.524.

____ Date: ____________________________

Signature of patient or representative authorized by law.

SEQUEL
Youth & Family Services

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES PURSUANT TO HIPAA

Patient Name	Date of Birth	Phone Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.
4. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 7(B).

5. Name and address of person(s) or category of person(s) to release this information:
Pomegranate Health Systems; 765 Pierce Drive, Columbus, OH 43223

6. Name and address of person(s) or category of person(s) to whom this information will be sent:

7(a). Specific information to be released:

☐ Psychotherapy Notes from (insert date) ___________ to (insert date) ________________________

☐ Entire Record of Psychotherapy Notes

☐ Other: ______________________________

____

Authorization to Discuss Health Information

(b) ☐ By initialing here ________ I authorize ____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____
(Attorney/Firm Name or Governmental Agency Name)

8. Reason for release of information: ☐ At request of individual ☐ Other:	9. If I do not specify a date or event in this box, this authorization shall expire 24 months from the date of my signature below.
10. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient: (If applicable, attach supporting documentation).

I understand that after I sign this Authorization I may receive a copy. I also understand that I may inspect or copy the information to be used or disclosed, as provided for in 45 C.F.R. § 164.524.

____ Date: __________________________

Signature of patient or representative authorized by law.