HIPAA Compliant Authorization for Release of Personal Information Pursuant to 45 CFR 164-508

I hereby authorize Monadnock Developmental Services (MDS) to use/disclose/receive/exchange my individually identifiable health information as described below with identified person(s) or organizations. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance co or health care provider, the disclosed information may no longer be protected by federal and state privacy regulations. I understand the disclosure of information may include paper copies, electronic transmissions and/or verbal unless otherwise restricted. I understand that eligibility of benefits, treatment, payment, and enrollment may be conditional upon obtaining individual authorization pursuant to eligibility criteria as defined in the state regulations He-M 503, He-M 510, He-M 519 and He-M 522.

Client Name _____ DOB _____

Client Address _____

Client Phone _____ Client Email _____

To disclose/receive information with:

Person/Organization Name _____

Address _____

Phone _____ Email _____

Purpose of Disclosure

☐ Medical Care ☐ Insurance ☐ Transfer to new provider ☐ Workers Comp ☐ Legal ☐ Coordination of Services ☐ Benefits

☐ Personal ☐ Early Supports & Services ☐ Eligibility ☐ Other _____

Health Information which may be released/exchanged includes

☐ Psychological ☐ Financial ☐ Educational ☐ Vocational ☐ Evals ☐ Complete Records ☐ Other _____

Medical Information which may be released/exchanged includes

☐ Discharge summaries ☐ Progress notes ☐ Operative records ☐ Consult reports ☐ Genetic test results ☐ x-rays & image reports

☐ Lab reports & test results ☐ Complete health records ☐ other _____

I understand that Alcohol/Drug Treatment records are protected under federal regulations (42 CFR Part 2). I understand that I have the right to refuse the release of this information. When Alcohol/Drug Treatment records are released the following notice shall be included. "This information has been disclosed to you from records and is protected by federal confidentiality rules 42 CFR Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person who it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient." By checking below I understand that this authorization extends to the release of those records that may be related to:

☐ Alcohol / Drug Treatment records ☐ HIV Diagnosis / Treatment records

Information to be released/exchanged is necessary in determining eligibility and/or the coordination of services. I understand that this release allows MDS and recipients to share information as requested throughout the validity of this release. I understand that a fax or photocopy of this release will have the same validity as the original authorization. Unless earlier revoked I understand this release terminates 1 year from date of signature or upon discharge from services. I understand that this authorization may be revoked at any time and I will do so in writing to MDS.

_____ _____

Individual, Parent or (co)Guardian - Signature Date

_____ _____

Individual, Parent or (co)Guardian - Print Name Relationship to Client

(Revised June 2018)