

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Return to: Jordan Valley Records Dept:440 E Tampa Springfield MO 65806 Email: Medicalrecords@jordanvalley.org Fax: 417-831-0155 Phone:417-831-0150

ALL sections of this authorization **MUST** be completed to be valid in accordance with 42 CFR Parts 160 and 164

Patient's Name: _____ Patient's Date of Birth: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Patient's Phone #: _____ Last 4 Digits of Social Security #: _____

I request my protected health information (PHI) be released **TO:**

Recipient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Fax # (to healthcare provider only); _____ Email Address: _____

I understand that once information is released to the above-named person or persons, my information may be subject to re-disclosure. I understand that any recipient to 42 CFR part 2 protected information must comply with part 2 protections and may not re-disclose the information except as permitted by part 2." 42 CFR §2.32.

I request my protected health information (PHI) **FROM:**

Organization/physician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Fax # (to healthcare provider only); _____ Email Address: _____

MEDICAL	DENTAL	BEHAVIORAL HEALTH
☐ ALL MEDICAL RECORDS ☐ With X-rays/Imaging ☐ Without X-rays/Imaging ☐ Medication List ☐ Immunization Records ☐ X-rays/Imaging ☐ X-rays/Imaging Reports ☐ Progress/Office Notes ☐ Speech Occupational Physical Therapy Records ☐ Lab/Pathology Results ☐ Pain Management ☐ Substance Use Treatment <i>Records include Counseling or Therapy Notes, MAT Medications, Urine Drug Screens</i> ☐ OTHER: _____	☐ ALL DENTAL RECORDS ☐ With X-rays/Imaging ☐ Without X-rays/Imaging ☐ Surgical Notes ☐ Lab/Pathology Results ☐ OTHER: _____	☐ ALL BEHAVIORAL HEALTH RECORDS <i>Records include Psychological Evaluations, Testing Notes, Psychiatric Assessments, Treatment Plan, Medication Records, Medication Labs</i> ☐ OTHER: _____
	VISION	BILLING STATEMENTS
	☐ ALL VISION RECORDS ☐ Glasses/Contacts Prescription ☐ Diabetic Retinopathy Exam ☐ Progress/Office Notes ☐ Imaging ☐ OTHER: _____	☐ ALL BILLING STATEMENTS ☐ Medical ☐ Dental ☐ Behavioral Health ☐ Vision ☐ OTHER: _____
		☐ ENTIRE CHART (ALL SERVICES)

Timeframe of Records Needed: From Date: _____ To Date: _____ OR Last Visit ☐

Unless otherwise specified only the most recent visit information will be provided

Delivery Method:

US Mail – paper format ☐ Pick-Up – paper format ☐ Fax # ☐ Electronic via secure encrypted email ☐

Purpose of Request (Must check one):

- ☐ Request of the Patient or Individual ☐ Coordination of Care/Treatment with Other Providers ☐ Personal Use
☐ Attorney/Legal ☐ Other (please specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse pursuant to 42 CFR §2. I also understand that medical or billing records may contain information in reference to psychiatric and psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, genetic information, sexually transmitted diseases, other communicable diseases, and/or other sensitive information.

I agree to its release unless otherwise specified here: _____

By not signing above, I authorize the use and disclosure of my Substance Use Disorder (SUD) treatment records, including Medication-Assisted Treatment (MAT) information in accordance with the updated 42 CFR Part 2 regulations aligned with HIPAA (effective 2026).

Time Limit, Right to Revoke Authorization, and Re-Disclosure

By signing this authorization form, I understand that:

- ◆ I have the right to revoke this authorization at any time, by submitting a notice in writing to Jordan Valley Health Attn: Medical Records. Revocation will not apply to information that has already been released in response to this authorization.
- ◆ Unless revoked, this authorization will expire **one year from date of signature** unless otherwise specified, or upon the following condition or event _____.
- ◆ Treatment, payment, enrollment or eligibility for benefits may **not be conditioned** on whether or not I sign this authorization.
- ◆ My SUD/MAT information may be redisclosed by the recipient in accordance with HIPAA, unless the information is protected by stricter federal laws. However, SUD/MAT information may **NOT** be used in civil, administrative, or legislative proceedings against me without my written consent or a court order that meets 42 CFR Part 2 requirements.

Patient/Authorized Representative Signature

Date

Printed Name of Authorized Representative

Relationship to Patient

Internal Office Use Only

Identity of Requester Verified via:

☐ Photo ID, Matching Signature

☐ Other, Specify: _____

Verified by: _____

NOTE: If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.