AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Information. ***Please PRINT legibly. All sections of this form must be completed.***

First Name: _____ Last Name: _____ M.I.: _____

Phone Number: Date of Birth:

I, as Client / Legal Guardian, authorize *ReDiscover* to:

Disclose to:	**Obtain from:**
○ Designated Recipient *(specify below)*	○ Designated Recipient *(specify below)*
○ Any entity or person in treating provider relationship with client	○ Any entity or person in treating provider relationship with client
○ Health Information Exchange and participants in treating provider relationship with client	○ Health Information Exchange and participants in treating provider relationship with client

For the purpose of: ○ Personal Use ○ Continuation of Care ○ Legal ○ Insurance ○ Other, specify:

This authorization applies to all applicable health information:

○ Including substance use disorder information ○ Excluding substance use disorder information

Designated Recipient Information:

Name / Organization: _____

Address: _____
Street Address City State Zip Code

Phone Number: _____ Fax Number: _____

Relationship to Client: E-Mail:

This Authorization becomes effective upon signing and will expire on _____ *(define date or event)*

If left blank, this Authorization will automatically expire one year after the date signed.

Except to the extent that health information has already been disclosed or obtained, I have the right to revoke this Authorization at any time by submitting my revocation in writing to ***ReDiscover***, 1555 NE Rice Rd., Lee's Summit, MO 64086, Attn: Privacy Officer.

I may refuse to sign this Authorization and such refusal will not affect my / the client's ability to obtain treatment unless otherwise prohibited.

Upon a written request to ***ReDiscover*** at the address above, I may request a List of Disclosures to which my / the client's health information has been disclosed within the last two (2) years of the request.

_____ _____
Client / Legal Guardian Signature Date

_____ _____
Client / Legal Guardian Printed Name If other than Client, relationship to Client

For office use only:	**SCANNING STAMP HERE**	**MR #:**