# AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

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|---|---|---|
| Site Name: | Moral Medical Justification LLC.<br>35000 Chardon Rd.<br>Suite 105<br>Willoughby Hills, OH 44094 | Physician: Dr. BJ. Sidari D.O., C.T.R.<br>440-510-8470<br>bjsidarido@protonmail.com<br>Fax: 216-910-4077 |

Patient Full Name (First, Middle, Last):_____Date of Birth:_____
Date of Services (Disclosure for a specific time period) Choose One:
___Most Recent Episode/Admission ___All Admissions/Episodes ___Previous Six Months
___Other (Specify)_____ From:_____ To:_____

I hereby authorize: Dr. Sidari to: ___Obtain From ___Release to ___Share/Discuss with
Information to be shared can be: ___Verbal only ___Written Records Only ___Verbal and Written Records

Name/Facility:_____Attention:_____

Address:_____City:_____State:_____Zip:_____

Phone Number:_____Fax:_____

**Check the following information to be released for the dates of service indicated above. The disclosure may include paper, oral and electronic interchange.**

**____Entire Medical Record (*Does not include HIV/AIDS Testing, Genetic Testing Information or Drug & Alcohol Information. To authorize the disclosure of this information, you must also check below*)**

| | | |
|---|---|---|
| ____Alcohol & Other Drug Diagnosis/Treatment Information | ____HIV/AIDS/ARC Information | ____Genetic Testing Information |
| ____Diagnostic Assessment | ____Psychiatric Diagnostic Evaluation | ____Peds Consultation Notes |
| ____Psychological Testing Evaluation Report | ____Progress Notes | ____Billing Statement |
| ____Medications | ____Treatment Plan | ____EAP Assessment |
| ____Discharge Summary | ____Diagnoses | ____EAP Notes |
| ____Other (must specify) | ____Urine Screens/Lab Results | ____EAP Discharge |

Purpose(s) of Disclosure: ___Coordination & Continuity of Treatment ___Family Involvement ___Personal ___Legal
___Insurance ___Transfer From Practice ___Aftercare/Follow-up
Other(explain/identify):_____

**Confidentiality Rules:** This information has been disclosed to you from records protected by federal confidentiality rules. 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. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. This Authorization to Disclose/Obtain Confidential Information will expire upon the date; condition, or event listed below:

Expiration date(cannot be dated beyond 12 months):_____Condition/event of expiration:_____

- I understand that if the recipient of the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such recipient and will likely no longer be protected by federal privacy regulations. I understand that () cannot control the recipients use of the disclosed information.
- I Understand that authorizing the use or disclosure of the above information is voluntary. I understand () will not condition about treatment, payment, enrollment, or eligibility for benefits on the execution of this authorization.
- I understand that I can revoke this authorization any time, except to the extent that action has been taken by () in reliance on this authorization, and that the revocation must be signed and dated by me. Upon revocation of this authorization, further release of information shall immediately cease. For more information about your privacy rights, please refer to () HIPPA Notice of Privacy Practices.

_____ _____ _____
Signature of Patient or Legally Authorized Representative | Print Name | Date

_____ _____
Relationship of Authorized Representative (if applicable) | PRINT Name of staff member facilitating request

_____ _____
Signature of Minor Client (For AOD Records Only) | Date

**I hereby REVOKE my consent for the release of the above information**

**Signature:_____ Date:_____ Relationship to Client:_____**

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