Authorization for Use or Disclosure of Protected Health Information (PHI)

CHE Behavioral Health Services
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This authorization is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164.

This form is intended to be used for the purpose of:

☐ Release of Medical records to a third party.

☐ Allow a third party to speak to CHE on my behalf

1. Patient Information

To process this request, the patient must provide full legal name, date of birth, address on file, and Social Security Number (or last four digits if full SSN not available) for identity verification purposes.

Patient Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

2. Person/Entity Authorized to Receive Information

Name of Person or Entity: _____

Relationship to Patient: _____

Phone:_____

3. Delivery Method (Select One):

☐ Encrypted Email (provide email address below)

Email Address: _____

☐ Mail

Address: _____

☐ Fax Transmission (provide number below):

Fax Number:_____

☐ Disclaimer: I understand there are potential privacy and security risks associated with transmission of protected health information through unsecured fax communication, including the possibility that the information could be intercepted or accessed by unauthorized individuals. I acknowledge and accept these risks and nonetheless request that my records be transmitted via the requested method.

3. Description of Information to Be Disclosed

This authorization applies to verbal, written, and electronic disclosures of the information described above.

☐ Complete health record

☐ Complete health record EXCEPT the following (specify): _____

☐ Specific records/date range (specify): _____

4. Purpose of Disclosure

☐ At the request of the individual

☐ Other (specify): _____

5. Expiration of Authorization

This authorization will expire on the following date or event (must complete one):

Expiration Date: _____

OR Expiration Event (e.g., end of treatment): _____

6. Individual Rights and Acknowledgments

Please read carefully and initial each statement:

_____ I understand that I may revoke this authorization in writing at any time. Revocation will not apply to information already released in reliance on this authorization.

_____ I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____ I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

_____ I understand that I am entitled to receive a copy of this signed authorization.

_____ I understand that CHE Behavioral Health Services may require reasonable proof of identity prior to releasing records.

_____ I understand that CHE may charge a reasonable, cost-based fee for copies of records as permitted under HIPAA (45 C.F.R. §164.524).

7. Signature

Identity Verification: To safeguard patient privacy, CHE Behavioral Health Services requires government-issued photo identification and additional identifiers (Patient Information) to verify identity prior to releasing protected health information. Verification requirements will not be applied in a manner that creates unreasonable barriers to an individual's right of access under 45 C.F.R. §164.524. If standard identifiers are unavailable, CHE will work with the individual to establish identity through alternative reasonable methods.

☐ Patient Name (printed): _____

Signature: _____ Date: _____

☐ Personal Representative Signature (Complete if applicable)

Documentation Required: A copy of valid government-issued photo identification AND legal documentation of authority (e.g., Power of Attorney or court-appointed guardianship papers) must be submitted before records are released.

Printed Name of Personal Representative: _____

Relationship to Patient: _____

Signature of Personal Representative: _____ Date: _____

Last Reviewed/Updated: May 12, 2026