Community Fairbanks Recovery Center

PATIENT IDENTIFICATION

SUBSTANCE USE DISORDER (SUD) RECORD AUTHORIZATION

Patient Information	NAME:_____ DATE OF BIRTH:_____ Last 4 digits of SS#: _____ Address:_____ Day Phone:_____ City:_____ State:_____ Zip: _____
General Use & Disclosure of Records	____ I authorize Fairbanks and Community Health Network to use and disclose my records for billing/payment and healthcare operation purposes.
Other Party (**Where** do you want the information sent? Who may share the information?)	NAME:_____ Email:_____ Address:_____ City:_____ State:_____ Zip:_____ Day Phone:_____ Fax Number _____
Information to be Released/ Obtained (**What** do you want shared? Check Obtain and/or **Release** for each item to be shared. Check all that apply.)	Obtain Release ____ ____ Admission, discharge and/or participation in treatment ____ ____ Assessment data (Initial Screening/Recommendations, Psychosocial) ____ ____ Clinical information (for example, History and Physical, Psychiatric Evaluation, Psychological Evaluation Nursing Assessment, Medical Screening, Immunization Records, Physician Orders, Vital Sign Records, Medication Administration Records, Medical Discharge Summary*) ____ ____ Medical recommendations to healthcare providers for treatment and ongoing management of narcotics and addictive substances ____ ____ Therapy information (for example, Flow sheets, Progress Notes/Reports, Treatment Plan, Recovery Plan, Counselor Discharge Summary) ____ ____ Diagnostic information (for example, labs, x-ray, EKG, Portable Breath Test [PBT], Urine Drug Screen [UDS]) ____ ____ Communicable disease information, including HIV/AIDS ____ ____ Medication reconciliation ____ ____ Legal/court documents (for example, court orders, placement agreements) ____ ____ Billing information (for example, face sheet, insurance card, itemized statement, billing arrangements, explanation of benefits and payment options) ____ ____ Electronic prescription (E-Prescribing) ____ ____ Other_____ ** Medical Discharge Summary contains laboratory and other diagnostic data* First date this authorization is valid: _____
Release Instructions (**How** and **When** do you want the information?)	Fairbanks reserves the right to disclose information for payment and healthcare operation purposes in the most appropriate format (for example, verbal, written, electronic, email, or fax), as permitted by this authorization and in accordance with applicable law. Release Method/Format requested: ☐MyChart ☐Paper ☐CD/DVD ☐Fax ☐Secure Email ☐Verbal ☐Electronic Format _____
Purpose of Release (**Why** is it needed?)	☐Data Gathering ☐Diagnosis & Evaluation ☐Discharge/Continuing Care Planning ☐Billing of and/or Communication with Payers ☐Visitation ☐Assessment/Treatment ☐Family Involvement in Treatment ☐Personal ☐Other _____

- This authorization lasts for one (1) year after the date I sign it unless I enter a different date or expiration here:_____. If the authorization is for billing and/or communication with Payers, this release shall remain active until the claim is settled with the Payer.
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happened before the cancellation. The Community Health Network Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- The confidentiality of the SUD records is protected by the Federal Confidentiality of Substance Use Disorder Patient Records Law (42 CFR Part 2). Fairbanks shall inform people who receive SUD records that 42 CFR Part 2 prohibits further disclosure of the records without written consent.
- I understand I may refuse to sign this authorization, and my refusal will not affect my ability to obtain services, treatment or payment for services **unless the services provided are solely to create health records for a third party, such as physical and drug testing for an employer or insurance company; or if treatment provided is research related and authorization is required for the use of health information for research purposes.**
- My signature indicates I read and understand this form, and I authorize Fairbanks to release or obtain my information as described above.

_____ _____
Patient Signature Date/Time

_____ _____
Parent/Legal Guardian Signature Authority to act on behalf of patient (attach document)

PLEASE PROVIDE A COPY OF THIS FORM TO THE PATIENT

Community Fairbanks
Recovery Center

DIRECTIONS FOR COMPLETION OF THIS FORM

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for).

Other Party: Identify the full name/business, address, phone and contact information of the other person/entity who is to receive or provide the information. Please allow 30 days for all requests to be processed and sent to the recipient.

Information to Be Released or Obtained: This section gives us the instructions for what information you want shared.

Release Instructions: This tells us how you would like your information delivered. We can print the documents, mail, secure email, or create a CD. If we are unable to provide in the format desired we will contact you to make other arrangements.

Purpose of Request: This helps us track and assign priority to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Fees: State and Federal laws permit fees to be charged for medical records. We do not charge patients for copies of their records

Contact Information:

Community Health Network
Health Information Management-ROI
1500 North Ritter Avenue
Indianapolis, IN 46219

Phone: 317.355.5802
Fax: 317.351.7728

For any questions/follow-up regarding your request please e-mail **releaseofinformation@eCommunity.com**

To submit a request for records please e-mail to **ROIRequests@eCommunity.com**