Release of Information

eleanor health

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION:

Member Information

First Name: _____ Last Name: _____

Date of Birth: _____ Home Clinic: _____

I authorize Eleanor Health[1] to use and disclose to, and receive information from:

Full Name: _____

Relationship: _____

Address: _____

Phone Number: _____ Fax: _____

I agree to the disclosure of the following health information ("Health Information") about me for the purposes of _____ as permitted by the Health Insurance Portability and Accountability Act ("HIPAA") (45 CFR Parts 160 and 164) and 42 CFR Part 2 Final Rule:
*required to check at least one box

☐ All Records

OR
Select Information (check boxes of information you wish shared)

☐ Presence in treatment
☐ Treatment plans
☐ Substance use disorder history and evaluation
☐ Psychiatric history and evaluation
☐ Discharge summary
☐ Progress notes
☐ Medical history and current status
☐ Laboratory test results
☐ Psychological testing
☐ Educational testing
☐ Financial Information
☐ Employment Information
☐ Family Information
☐ Other health information
Please list: _____

I understand that my Health Information is protected by HIPAA, and that my substance use disorder records are protected by federal regulations governing the confidentiality of such records (42 C.F.R. Part 2 Final RUle), and cannot be disclosed without my written consent unless permitted by such laws. I understand that my Health Information may contain information concerning my mental health diagnosis and treatment, substance use disorder diagnosis and treatment, and HIV, AIDS, and sexually transmitted disease testing, diagnosis, and treatment.

[1]I authorize Eleanor Health Professional NC, PLLC; Eleanor Health Professional NJ, LLC; Eleanor Health Professional MA, PLLC; Eleanor Health Professional WA, PLLC; Eleanor Health Professional LA, LLC; Eleanor Health Professional OH, LLC; Eleanor Health Professional TX, PLLC; Eleanor Health Professional FL; Eleanor Health Professional NM (each an Eleanor Health Entity or collectively "Eleanor Health") to use and disclose to, and receive information from:

I understand that my Health Information may be subject to re-disclosure by any individual or entity receiving the Health Information and may no longer be protected by law. I understand that I may revoke this authorization in writing at any time by contacting Eleanor Health at www.eleanorhealth.com except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire when Eleanor Health no longer needs to use, disclose, or receive my Health Information for a treatment, payment, or health care operations purpose.

I understand that I may be denied services if I refuse to consent to Eleanor Healthís disclosure and receipt of Health Information for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to Eleanor Health's disclosure and receipt of my Health Information for other purposes. I have been provided a signed copy of this Consent.

I am at least 18 years of age and am competent to contract in my own name. I have read this Consent before signing below and I fully understand the contents, meaning, and impact of this Consent.

_____ _____

Signature of Eleanor Health Community Member *Date*

**I understand that by entering my name, I am providing an electronic signature which carries the same legal effect as my handwritten signature.*

FOR ADULTS WHO LACK CAPACITY TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS

I attest that I am the legal guardian, parent of the Eleanor Health Community Member, or other individual authorized to consent to treatment on behalf of the Eleanor Health Community Member. On the Eleanor Health Community Memberís behalf, I authorize Eleanor Health to disclose and receive the Health Information indicated above for the purposes indicated above.

_____ _____

Authorized Representative Name *Signature of Authorized Representative*

_____ _____

Relationship to Eleanor Health Community Member *Date*

**I understand that by entering my name, I am providing an electronic signature which carries the same legal effect as my handwritten signature.*

PROHIBITION ON RE-DISCLOSURE.

Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by the following written statement: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

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