Polara Health
Windhaven Psychiatric Hospital, Primary Care HIM Dept.
642 Dameron Dr. Prescott, AZ 86301
Phone: (928) 445-5211 ext. 4007    Fax: (928) 717-1204

I __________________________________________ (Date of Birth __________) authorize Polara Health to disclose:
Print Clients Name

Obtain Information From    Release Information To    Discuss With

Category: Individual    Non-Treating Provider    Third Party Payer    Treating Provider
Relationship: Attorney    Court    Friend    Other    PCP    Relative

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Name of Agency/Facility: ____________________

Name of Person (s): ____________________

Address of Agency/Facility/Person: ____________________

Home/Office Phone Number: ____________________ Fax Number: ____________________

Email Address: ____________________

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Preferred Disclosure Format:
US Mail    Fax    Electronic Transmission    Pick Up
Other    Verbal    Text    Exchange Portal
Specify Other: ____________________

Electronic Transmission or Text Disclosure:
Email and Texting are not secure methods of communicating. If you selected either of these boxes you are authorizing Polara Health to use these instruments and you are accepting the risks associated with a potential breach of your PHI.

Initial here if you accept the risk: ________

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What kind of information do you want released:
Outpatient    Crisis Observation    Inpatient/Hospitalization    Residential    Primary Care

What is the purpose of the Release: ____________________
Legal    Insurance    Coordination of Care    Evaluation and Treatment Planning
Medical Leave    Copies for personal use    Other    Emergency Contact    Assist in my recovery
Outreach and Engagement
Specify Other: ____________________

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**Special Treatment Records Selection, If Any:**
Include the following:
HIV/AIDS (Including Test Results)
All of my substance treatment records
None of my substance treatment records
All of my medications including substance treatment medications
All of my lab test results including substance treatment results
Discharge summary including substance treatment information
Other substance treatment records
Specify other SUD/SA Treatment Records to be disclosed: ____________________

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Select which Behavioral/Medical Health Records to be Released:
Clinical Assessments    History and Physical    Lab Results    Imaging
Crisis Assessments    Treatment Plan(s)    Medication Records    Psychiatric Evaluation
Other    Progress Notes    Discuss Progress    Diagnosis
Inpatient/Detox DC Instructions/Summary    Alcohol and Drug Screening Results
Records of Attendance in Program    ☐ Appointment Reminders
Specify Other Behavioral/Medical Health Records: ____________________

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Select which types of Progress Notes:

Case Management | DSP | Therapy | Psychiatry | Medical | Nursing

Social Work | Peer Support | Other

Specify Other Progress Notes: ______________________________

Records Covering:

Most recent 2 years | Upon Request | Specific Coverage Date Range Start __________ End __________

All past, present, and future encounters/visits | Now and Upon Request

I understand that information released may include information regulated by Federal Public Law 93-282, and information protected by 38 U.S.C. 7332. It also may include confidential information regarding the testing, diagnosis, or treatment or HIV/AIDS (as defined in A.R.S. Section 36-661), sexually transmitted diseases (as defined in A.R.S. Section 36-661), chemical dependency (as defined in 42 CFR section 2.1 et seq.) or mental/psychiatric illness and for patients 13-17, information regarding reproductive care. By signing below, I give my specific authorization for this information to be released.

I understand that Polara Health is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that the clinic will not condition treatment on my signing this authorization. The clinic will not deny me treatment if I do not wish to sign this form.

I understand that I may revoke this authorization in writing with some exceptions. For more details on when I can and cannot revoke the authorization I can read the clinic's Notice to Privacy Practices. If I revoke my authorization, it will not affect any actions already taken based upon the authorization.

Unless otherwise revoked, this authorization expires on the following date or the event specified:

Expiration Date __________ or Expiration Event and/or Condition ______________________________

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Client/Patient Name ______________________________ Date of Birth: __________

Client or Representative Signature ______________________________

Name (please print) ______________________________ Date __________ Phone __________

Relationship to Client/Patient ______________________________

Signature of minor ages 13-17 is required for certain information:

Client or Representative Signature ______________________________ Date __________

This information has been disclosed to you from records protected by federal confidentially 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 abuse 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 as to investigate or prosecute with regard to a crime any patient with a substance abuse disorder, except as provided at 2.12(c)(5) and 2.65.