



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

Name of Agency/Facility: _____

Name of Person (s): _____

Address of Agency/Facility/Person: _____

Home/Office Phone Number: _____ Fax Number: _____

Email Address: _____

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 WYGC 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: _____

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: _____

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: _____

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: _____



GUIDING YOUR WAY TO WELLNESS SINCE 1966

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

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 WYGC 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 _____

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 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 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.