Solutions Outpatient Services

CLIENT NAME: _____
CLIENT NUMBER: _____
DATE OF BIRTH: _____
SCREENING/ADMIT DATE: _____

Authorization to Release and/or Request Protected Health Information (PHI) From and/or to Other Professionals

I hereby authorize Solutions Outpatient Services to disclosure PHI to and/or from the following professional:

and

Solutions Outpatient Services
4300 Mac Arthur Avenue, Suite 270
Dallas, Texas 75209
Phone: (214) 369-1155
Fax: (214) 369-1710
Email: info@sosdallas.com
Website: www.sosdallas.com

_____
Name Relationship/Title

_____
Company Name (if applicable)

_____
Street Address or PO Box

_____
City State Zip Code

_____
Phone Number

_____
Email Fax Number

Check all types of PHI to be disclosed and/or received to the above party:

INFORMATION	TO BE RELEASED BY *SOS*	REQUESTED BY *SOS*
Medical History	_____	_____
Physical Exam/Lab Results	_____	_____
Social History/Assessment	_____	_____
Chemical History/Assessment	_____	_____
Psychological Evaluation	_____	_____
Change in Condition or Status	_____	_____
Discharge/Transfer Summary	_____	_____
Aftercare/Continuing Care Planning	_____	_____
Other (specify) _____	_____	_____

Information and records requested may include reference to my HIV/AIDS status (Check Below):
_____ I do want this included _____ I do not want this included or it is NOT APPLICABLE

Check all methods for releasing PHI: ___ In Person ___ Telephone ___ Written ___ Email ___ Facsimile ___ Telehealth Communication

Check why the information is needed: _____ Legal (specify case type) _____
_____ Benefits/insurance related
_____ Other _____

I understand that:

- My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed with my authorization except in limited circumstances described in Solutions' Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
- I can revoke this consent at any time except to the extent that action has been taken in reliance on it. Solutions' Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign it unless I request an earlier expiration in writing.
- For disclosures other than for treatment, payment and health care operation purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42CFR, 164.508(b)(4)(iii)]).
- Communications resulting from this authorization will reveal that I received services at Solutions.
- Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Solutions to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA rules.

Client Signature _____ Date: _____

Parent/Guardian Signature (if applicable) _____ Date: _____

Intake Staff Signature _____ Date:_____

QCC _____ Date: _____
(if Intake Staff is not a QCC)