AUTHORIZATION TO RELEASE/REQUEST PROTECTED HEALTH INFORMATION

(THIS AUTHORIZATION SERVES AS THE CONSENT REQUIRED BY 42 CFR § 2.31 REGARDING THE TREATMENT RECEIVED AT MEDMARK TREATMENT CENTER.) *YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION. THE MEDMARK TREATMENT CENTER FROM WHICH YOU RECEIVE TREATMENT ("MEDMARK") WILL NOT WITHHOLD TREATMENT, BENEFITS, OR PAYMENT PROCESSING IF YOU REFUSE TO SIGN THIS AUTHORIZATION, UNLESS MEDMARK NEEDS THIS AUTHORIZATION FOR THE PURPOSE OF PROVIDING RESEARCH-RELATED TREATMENT OR SERVICES TO YOU OR THE SOLE PURPOSE FOR TREATMENT BY MEDMARK IS THE CREATION OF PROTECTED HEALTH INFORMATION THAT IS TO BE DISCLOSED TO A PARTY OTHER THAN MEDMARK. YOU WILL RECEIVE A SIGNED COPY OF THIS AUTHORIZATION.*

I, _____ _____ _____ _____

(Client's LAST Name) **(FIRST Name)** **(MI)** **(Date of Birth)**

hereby authorize the designated staff at MedMark to (please check one):

( ) Release the following information concerning me, **OR** ( ) Request the following information concerning me:

( ) Full Disclosure of all protected health information, including any substance use disorder ("SUD") information, **OR**
(X) All Medical Records including records related to SUD
( ) Intake Assessment, including any records related to SUD information
( ) Treatment Plan, including any records related to SUD information
( ) Psychiatric Evaluation, including any records related to SUD information
( ) Discharge Plan, including any records related to SUD information
( ) Discharge Summary, including any records related to SUD information
(X) Progress/Status in Treatment, including any records related to SUD information
( ) Presence In/Discharge from Treatment, including any records related to SUD information
(X) All laboratory test results, including any records related to SUD information
( ) Payment/billing information, including any records related to SUD information

To the extent items and information in my records were created or maintained by another provider, I also hereby authorize the use/disclosure/receipt of my Protected Health Information provided by such provider(s) regarding:
( ) psychotherapy notes & treatment, including any records related to SUD information ( ) counseling sessions, including any records related to SUD information ( ) Substance Use Disorder Treatment, including any records related to SUD information ( ) HIV/AIDS, including any records related to SUD information

TO:

☐ Named Individual: _____ (include individual's full name)

☒ Named Entity(ies) that have a treating provider relationship with me (i.e. hospital, health care clinic or private practice): _____

☐ Named Third-Party Payer (i.e., Medicaid or commercial insurance): _____

☐ Named Entity(ies) without a treating provider relationship with me: _____
(this includes health information exchanges, employers, schools, law offices, etc.)

- If selected at least one of the following boxes must also be checked and completed as applicable:
  - ☐ Named individual participant: _____
  - ☐ General designation of individual or entity or class of participants with a treating provider relationship (i.e. "my mental health team at ABC Hospital"): _____

    _____

    (If general designation is selected, upon you or your representative's request, MedMark will provide a list of entities to which your information was disclosed.)

The purpose for this disclosure is: Participate with MedMark Guest Dosing

Exclusions (please describe): _____

- **PROHIBITION OF RE-DISCLOSURE BY RECIPIENT: IF THE INFORMATION YOU ARE AUTHORIZING FOR RELEASE INCLUDES SUBSTANCE USE DISORDER TREATMENT INFORMATION, YOUR INFORMATION HAS BEEN DISCLOSED FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATION (42 CFR PART 2) PROHIBITS THE RECIPIENT FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT YOUR SPECIFIC WRITTEN CONSENT, OR AS OTHERWISE PERMITTED BY SUCH REGULATION. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.**
- Despite the foregoing prohibition for substance use disorder treatment information, the potential exists that certain Protected Health Information held by MedMark may be re-disclosed by the recipient ***IF*** you are authorizing the disclosure of your records and your records include Protected Health Information ***other than information created while receiving treatment at MedMark***. If such non-MedMark treatment information is re-disclosed by the recipient, it is no longer protected by medical privacy laws.
- If you are signing this authorization as a parent/guardian/managing conservator of a minor or as a personal representative or guardian of an adult, the Protected Health Information used/disclosed/received may contain references about you or your family.
- You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to MedMark specifically stating your intent to revoke this authorization. Revocation of this authorization will be effective the date it is received by MedMark, except to the extent MedMark has already relied upon your authorization to use or disclose your Protected Health Information as described in MedMark's Notice of Privacy Practices.
- **Unless revoked earlier in writing, this authorization will expire on (date, event, or condition of expiration) (90 days after the date of signature if left blank): _____.**
- By signing this authorization, you are authorizing MedMark to transfer through the use of any electronic means your Protected Health Information to, or receive your Protected Health Information from, the organization, entity or person designated above.

_____ _____

Signature – Patient Date

_____ _____

Signature – Patient Representative, if any Date

_____

Representative's Relationship to Patient

I confirm that the above signature is the signature of the individual providing this authorization.

_____ _____

Name of Witness Signature of Witness

A photocopy or facsimile transmission is as valid as the original.

MedMark Clinic Location: MedMark Treatment Center El Paso

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