

CANVAS HEALTH
CONSENT FOR THE RELEASE OF PRIVATE INFORMATION



| | | | | | | | | | | | | | | | |
|---|---|--|---|---|--|---|---|---|--|---|---|---|---|--|--|
| Client Information | Name _____ Previous Name _____ Date of Birth _____ Daytime Telephone # _____ Address _____ City _____ State _____ Zip _____ | | | | | | | | | | | | | | |
| Health Information Release | <input type="checkbox"/> I authorize Canvas Health to RECEIVE information FROM: <input type="checkbox"/> I authorize Canvas Health to RELEASE information TO: Provider/Person/Organization Name _____ Address _____ City _____ State _____ Zip _____ Telephone _____ Fax _____ | | | | | | | | | | | | | | |
| Purpose of Disclosure | <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Client Request <input type="checkbox"/> Legal/Attorney <input type="checkbox"/> Other – please explain _____ | | | | | | | | | | | | | | |
| Health Information to be Released | <input type="checkbox"/> Entire Health Record (includes all records listed below) <hr/> <input type="checkbox"/> Part of Health Record (check one or more items) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Mental Health Diagnostic Assessment</td> <td><input type="checkbox"/> Psychiatric Evaluation</td> </tr> <tr> <td><input type="checkbox"/> Mental Health Treatment Plan</td> <td><input type="checkbox"/> Medication Information/Labs</td> </tr> <tr> <td><input type="checkbox"/> Mental Health Progress Notes/Discharge Summary</td> <td><input type="checkbox"/> Psychological Evaluation</td> </tr> <tr> <td><input type="checkbox"/> Substance Use Rule 25 Assessment/Diagnosis/Summary</td> <td><input type="checkbox"/> Physical Health Records</td> </tr> <tr> <td><input type="checkbox"/> Substance Use Progress Notes/Discharge Summary</td> <td><input type="checkbox"/> Hospital Treatment/Discharge Summary</td> </tr> <tr> <td><input type="checkbox"/> Substance Use Treatment Plan</td> <td><input type="checkbox"/> Academic Records</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other (please describe) _____</td> </tr> </table> Specific dates of service _____ | <input type="checkbox"/> Mental Health Diagnostic Assessment | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Mental Health Treatment Plan | <input type="checkbox"/> Medication Information/Labs | <input type="checkbox"/> Mental Health Progress Notes/Discharge Summary | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Substance Use Rule 25 Assessment/Diagnosis/Summary | <input type="checkbox"/> Physical Health Records | <input type="checkbox"/> Substance Use Progress Notes/Discharge Summary | <input type="checkbox"/> Hospital Treatment/Discharge Summary | <input type="checkbox"/> Substance Use Treatment Plan | <input type="checkbox"/> Academic Records | <input type="checkbox"/> Other (please describe) _____ | |
| <input type="checkbox"/> Mental Health Diagnostic Assessment | <input type="checkbox"/> Psychiatric Evaluation | | | | | | | | | | | | | | |
| <input type="checkbox"/> Mental Health Treatment Plan | <input type="checkbox"/> Medication Information/Labs | | | | | | | | | | | | | | |
| <input type="checkbox"/> Mental Health Progress Notes/Discharge Summary | <input type="checkbox"/> Psychological Evaluation | | | | | | | | | | | | | | |
| <input type="checkbox"/> Substance Use Rule 25 Assessment/Diagnosis/Summary | <input type="checkbox"/> Physical Health Records | | | | | | | | | | | | | | |
| <input type="checkbox"/> Substance Use Progress Notes/Discharge Summary | <input type="checkbox"/> Hospital Treatment/Discharge Summary | | | | | | | | | | | | | | |
| <input type="checkbox"/> Substance Use Treatment Plan | <input type="checkbox"/> Academic Records | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other (please describe) _____ | | | | | | | | | | | | | | | |
| External Records | <input type="checkbox"/> All Substance Use <input type="checkbox"/> All Mental Health <input type="checkbox"/> Specify: _____ | | | | | | | | | | | | | | |
| Method of Delivery | <input type="checkbox"/> Written <input type="checkbox"/> Verbal <input type="checkbox"/> Encrypted email (Client only) Email: _____ (Please select all that apply) | | | | | | | | | | | | | | |
| Authorization | <p>This authorization expires (ends) on the following date, event, or condition _____ This authorization will expire no more than 12 months from the date I sign this form unless otherwise specifically permitted by law.</p> <p>I understand that:</p> <ul style="list-style-type: none"> • I may revoke this authorization at any time by notifying, in writing, Canvas Health. • Revoking this authorization does not apply to information that has already been disclosed under this authorization. • I have the right to inspect or obtain a copy of the health information disclosed. • If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws it will be protected by federal privacy laws. Information that goes to other persons/entities may not be protected by state or federal privacy laws and may be re-disclosed. • Canvas Health cannot prevent the re-disclosure of protected health information releases as a result of this request and therefore, Canvas Health is released from any and all liability resulting from re-disclosure. • If this release involves the disclosure of information concerning a client who is in alcohol or drug abuse treatment, this information has been disclosed from records protected by federal confidentiality rule, 42 CFR, Part 2. The federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. • I do not have to sign this form. Treatment may still be provided to me if I do not sign this form. <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Signature of Patient or Patient’s Representative</td> <td style="width: 50%; border-bottom: 1px solid black;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Print Name of Representative</td> <td style="border-bottom: 1px solid black;">Relationship to Client</td> </tr> </table> | Signature of Patient or Patient’s Representative | Date | Print Name of Representative | Relationship to Client | | | | | | | | | | |
| Signature of Patient or Patient’s Representative | Date | | | | | | | | | | | | | | |
| Print Name of Representative | Relationship to Client | | | | | | | | | | | | | | |

Revised 10/22/19