MIND SPRINGS *health*

WEST SPRINGS *hospital*

Authorization for Use and Disclosure of Health Information

Last Name _____ **First Name** _____ **Middle** _____ **Date of Birth** _____

I hereby authorize Mind Springs Health/West Springs Hospital to use or disclose health information about me.

QHN Authorization:

_____**By initialing here,** I authorize Mind Springs/West Springs to disclose my treatment information, including all substance use disorder information to Quality Health Network (QHN), where it can be accessed by all past, present, and future QHN participants who have a treating provider relationship with me. QHN is a health information exchange that moves clinical information among healthcare providers and systems with the purpose to provide coordinated, timely, and patient-centered care. I understand that I am entitled, upon request, to a list of all QHN participants to whom my information was disclosed.

Other Person or Entity to Whom Information May be Disclosed:

Name (list person and agency name when applicable)

Address

Phone: _____ Fax: _____

Particular information to be used or disclosed includes: (Please **INITIAL** only those that apply)

_____	Assessment, diagnosis	_____	Legal information
_____	Medication assessments, records	_____	HIV/AIDS information
_____	Update and/or discharge summaries	_____	Medical/lab information
_____	Social history, background	_____	Payment and balance related information
_____	All substance use disorder information	_____	Evaluations or testing
_____	Other (specify)	_____	Other (specify)

The information to be released will be used for the following purposes: (Please **INITIAL** only those that apply)

_____	Continuity of care	_____	Additional evaluation or treatment
_____	Service planning	_____	Multi-agency coordination of care
_____	Treatment, payment or healthcare operations	_____	Obtaining basic needs or benefits for the client
_____	Vocational service/vocational rehabilitation	_____	Reports to courts or other agencies
_____	At the request of client or personal representative	_____	Other _____

☐ **(Hospital Use Only) Allowed Visitations** ☐ **Yes** ☐ **No** ☐ **(Hospital Use Only) Telephone Calls Allowed** ☐ **Yes** ☐ **No**

Other information about this authorization: My ability to obtain services at Mind Springs Health/West Springs

Revocation: I revoke my authorization for this use and disclosure of my health information, effective immediately.		
Client signature	Date	Witness Signature
Representative signature	Date	If Representative, relationship to client

Hospital does not depend on signing this authorization unless a court or other authorized third party has required my treatment. Mind Springs Health/West Springs Hospital cannot guarantee that recipients of the information disclosed through this authorization will not re-disclose to another party. I understand that the recipient may or may not be subject to federal laws protecting health information. **I understand this authorization may be revoked at any time, in writing. If not revoked, I understand this authorization will expire in two (2) years.**

MEDICAL RECORDS PHONE NUMBER: (970) 683-7252; FAX NUMBER: (970) 683-7055

☐ **CLIENT DECLINED**

Client or Representative Signature	Date	If Representative, relation to Client

Witness Name

STAFF USE ONLY

Mind Springs Health _____ West Springs Hospital _____

HEALTH RECORD INFORMATION USED WITH BEGIN DATE _____

CLIENT ID # _____ ID Validated _____