Connect. Improve. Achieve.

Authorization for Use and Disclosure

Client Name **Date of Birth**

First Last

Client Address

Address Line 1

Address Line 2

City State Zip Code

Client Email

The person(s), or class of persons, authorized to receive the information:

Name and relationship

Description of the information that may be used and disclosed:

☐ Authorization status ☐ List of referrals

☐

My protected health information may be used and disclosed by BPA Health for the following purpose(s). Select all that apply:

☐ Coordinate care ☐ Support ☐ Emergency contact

☐

This authorization will automatically expire on the following date or event:

Date or event

I understand that this authorization is voluntary and that I have the right to to refuse to sign this. I understand that BPA Health may not condition my treatment, payment, enrollment, or eligibility for benefits whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization.

I understand that my records are protected under federal law, including the Health Information Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 Subparts A and E and, if applicable, the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that if the person or entity recieives the information is not a person or covered entity by privacy regulation, the information described above may be re-disclosed and is no longer protected by those regulation.

Pursuant to BPA Health's Notice of Privacy Practices, I understand I may revoke this authorization at any time except to the extent that action may have been taken in reliance on this authorization. To revoke this authorization I understand I must deliver notice, in writing to BPA Health's Privacy Officer at the following address:

BPA Health

Attn: Privacy Officer

8050 W. Rifleman St., Suite 100

Boise, ID 83704

Signature of Client or Legal Guardian

Date Signed

Name of Legal Guardian, if applicable

First

Last

Relationship of Legal Guardian

Relationship

This form can be submitted electronically (click submit below), or printed, completed and faxed to BPA Health at 208-344-7430. If submitted electronically you will be emailed a copy of the form. If you would like to receive a print copy in the mail, indicate below.

Would you like a printed copy of this form mailed to you?

○ Yes ○ No