Authorization for Use and Disclosure

Each form should only include one individual contact. If you have multiple contacts, please complete a separate form for each one.

Client Name *

First

Last

Date of Birth *

Client Address

Address Line 1

City

State

Zip Code

Client Email

Client Phone *

The person (first and last name), agency, or entity authorized to receive the information: *

Name and relationship

Example: Idaho District # Probation and Parole, ABC Treatment (Boise, Idaho).

Contact Person's Phone *

Description of the information that may be used and disclosed: *

☐ Authorization status ☐ List of referrals ☐ Other

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 ☐ Other

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 regulations.

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.

Signature of Client or Legal Guardian *

×

draw type

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 emailed to BPA Health at forms@bpahealth.com. 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

Submit