# Omega Mental Health Services

## Authorization to Release/Request Medical Information and/or Medical Records

## PLEASE FILL OUT COMPLETELY—THIS MUST BE SIGNED AND DATED

**Patient Name:**_____ **Date of Birth:**_____ **SSN**:_____
PLEASE PRINT

**FROM/TO:** _____
Circle One Physician/Institution/Person

_____
Street Address

_____
City State Zip

_____
Phone Fax E-mail

**FROM/TO:** Omega Mental Health Services
Circle One Physician/Institution

5985 W State Street
Street Address

Boise ID 83703
City State Zip

208-853-0071 208-853-9422 medicalrecords@omegahealthservices.com
Phone Fax E-Mail

Notice to Recipient: If these records contain information relating to alcohol and/or drug abuse, then the information is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is epressly permitted by the written consent of the patient or as otherwise permitted by 42 CFR Part 2.

**Release the following PHI:** ☐ all dates ☐ most recent visit ☐ last year ☐ last two years ☐ Other_____
Specific Dates of Service

- ☐ All Substance Abuse/Mental Health Records
- ☐ Chart Notes
- ☐ Therapy Notes
- ☐ X-Rays/Labs
- ☐ Medications/Medication Log
- ☐ HIV
- ☐ Correspondence
- ☐ Other (please specify):_____

**Information listed above will be used or disclosed for continuity of care only.**

This authorization is in full force and effect until ***1 year from the date of signature*** or until revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Omega.

- I understand that when I revoke this authorization, it is not effective to the extent that OHS has already relied on the use or disclosure of the PHI.
- Omega will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating PHI for disclosure to a third-party (such as an exam for work).
- I understand that I have a right to inspect or copy the PHI to be used or disclosed.
- I understand that I have a right to refuse to sign this authorization.
- If you have any questions concerning this form, please contact our Medical Records Department.
- I understand that by signing this release I am authorizing sensitive health information to be sent to the above recipient.

_____
(Signature or Patient, Personal Representative, or Parent/Guardian) Date



ADMIN ONLY:
Provider seen at our office:_____