Authorization for Disclosure of Protected Health Information
Good Samaritan Society

Resident/Client Name:_____ Date of Birth:_____

Phone Number:_____

Release Information **FROM:**	
Good Samaritan Society Location:	
Name	
Street Address	
City	
State	Zip Code
Phone	Fax

Release Information **TO:**	
Specify organization, department or individual below	
Name	
Street Address	
City	State
Zip Code	Email Address
Phone	Fax

Purpose of Release:

☐ Continuing Medical Care ☐ Work Comp ☐ Disability Determination ☐ Personal
☐ Insurance Claim ☐ Application for Insurance ☐ Legal ☐ Other:_____

Delivery Method: (Select One)

☐ Secure Email ☐ USB Flash Drive (mailed to requestor)	☐ Paper (choose one of the below options) ☐ Mailed ☐ Picked up at GSS location ☐ Faxed

Information to be Released:

Service Dates to be released: From: To: AND ☐ all future requested records until authorization expires

☐ Medication Summary	☐ Progress Notes	☐ Billing Claims
☐ Administration Record	☐ Immunization Report	☐ Itemized Billing Statements
☐ Care Plan/Service Plan	☐ Legal Medical Record	☐ Other_____
☐ Diagnosis Report		

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____Do **not** release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. **This authorization expires one year from the date of my signature unless I specify a different event, purpose, or alternative expiration date here:**_____

Signature:_____ **Date:**_____ **Time:**_____

Printed name:_____ **Email:**_____ **Phone:** _____

Legal Relationship to resident/client: _____
(If not resident/client such as healthcare POA, executor of the estate): Provide legal paperwork to support legal relationship.

Internal Use Only: Date Received_____ Date Released_____

Good Samaritan Society®