Chwen-Yuen Angie Chen, MD, FACP, FASAM
Addiction Medicine MD
Board Certified, American Board of Internal Medicine
Diplomate of the American Board of Addiction Medicine
1900 O'Farrell Street, Suite 190, San Mateo, CA 94403
Phone 650-503-4115 ~ Fax 888-755-4489 ~ www.addictionmedicinemd.com

AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, ALCOHOL, SUBSTANCE USE RECORDS, HIV/STD/TB RELATED INFORMATION (RELEASE OF INFORMATION) – ROI – CFR42 Part 2

PATIENT INFORMATION:

Patient/Client Name (PRINT)_____
DOB_____ Telephone _____
Maiden Name/Other Name Used in the Past _____
Dates of treatment covered by this authorization: From_____ To_____

EXPLANATION:

This authorization conforms to requirements of State and Federal laws governing release and receipt of Protected/Patient Health Information (PHI).

AUTHORIZATION:

I hereby authorize **Chwen-Yuen Angie Chen, MD, along with any ReMeDy staff or personnel including *any and all on call physicians* who reside at ReMeDy Medical Group at *1900 O'Farrell Street, Suite 190, San Mateo, CA 94403*** reciprocal release of my records, and to disclose information from my records to the recipient(s) listed below, even though such information is otherwise confidential and/or privileged.

(Please PRINT information of person(s) or organization(s) to which disclosure is to be made):

Name _____ (Provider)
Address _____
City_____, State_____, Zip Code_____
Phone_____ Fax _____

Name _____ (Provider)
Address _____
City_____, State_____, Zip Code_____
Phone_____ Fax _____

Name _____ (Family/Friend/Other)
Address _____
City_____, State_____, Zip Code_____
Phone_____ Fax _____

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INFORMATION WHICH MAY BE RELEASED:
The following information (Nature of the information to be disclosed, as limited as possible):
Please initial:

_____ Evaluations/Drug Testing/Assessments/Treatment Plans **of Drug and Alcohol Use Disorder(s)**
_____ HIV Diagnosis
_____TB Diagnosis and any treatment
_____STD Diagnosis and any treatment
_____OTHER Specify: _____

DISCLOSURES TO PHARMACIES AND LABORATORIES
I also authorize Dr. C.Y. Angie Chen and the personnel at ReMeDy Medical offices to disclose information to the any dispensing pharmacy to whom I present my prescription or to whom my prescription is called/sent/faxed, as well as to third party payers:

_____
(Name and Location of Preferred Pharmacy, however SUBECT TO CHANGE PER VISIT)

For the following purpose: Any information needed to confirm the validity of my prescription and for submission for payment for the prescription, assuring the pharmacy of the validity of the prescription, so it can be legally dispensed, and for payment purposes.

I also authorize Dr. C.Y. Angie Chen and the personnel at ReMeDy Medical offices to disclose information to any **laboratory**, which Dr. C.Y. Angie Chen uses for testing in order to verify my identity and communicate results.

EXCEPTION(S): Information That You Do Not Want Released (be specific):

_____

PURPOSE OF DISCLOSURE
The purpose of the disclosure authorized herein is to: communicate and coordinate care with the above names of providers and other persons regarding the treatment of my drug and alcohol use disorder (s) as well as any primary care issues and HIV/STD/HCV/TB care if applicable.

PATIENT'S RIGHTS
I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

***EXPIRATION OF THIS DISCLOSURE** _____
(MM/DD/YYYY)
*This authorization **expires one year from date signed or as otherwise specified**.

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RIGHT OF CLIENT TO RECEIVE A COPY OF AUTHORIZATION:
I understand that I have the right to receive a copy of this signed authorization.
I have received a copy of this authorization. Yes ____No _____

I understand that authorizing the use or disclosure of the information identified above is voluntary. Chwen-Yuen Angie Chen, MD will not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization.

Signature of Patient _____

Date Signed_____

Verification of client's ID at point of signature was completed and confirmed by my signature:

Witness _____

Signature of parent or guardian (where required) _____

Signature of person authorized to sign in lieu of the patient (where required) _____

PROHIBITION ON REDISCLOSURE
OF INFORMATION CONCERNING CLIENT
IN ALCOHOL OR DRUG ABUSE TREATMENT

This information has been disclosed to you from records 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 expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.