ALVARADO PARKWAY INSTITUTE
BEHAVIORAL HEALTH SYSTEM

INSTRUCTIONS

REQUESTING YOUR PROTECTED HEALTH INFORMATION (PHI)

You will need to download, print, and complete the *Authorization to Release/Obtain Protected Medical/Psychiatric Health Information* form.

There is NO FEE when records are being requested for release to a physician, psychiatrist, or other healthcare provider for your continuing care or treatment. Please remember to **include your phone number and sign** the *Authorization to Release/Obtain Protected Medical/Psychiatric Health Information* form, before forwarding it to us. Please be aware that there may be a charge involved when requesting PHI for your personal use.

We work diligently to complete each request promptly and accurately. Every approved request must be processed within 14 business days of receipt.

It is necessary to complete entirely both (1 & 2) pages of the *Authorization to Release/Obtain Protected Medical/Psychiatric Health Information* form. There are a few pieces of information ***required*** from you prior to the processing of your request for PHI release.

Please complete points 1 *through* 11 noted on the sample below.

(NOTE: # 11 is only required under conditions mentioned on the form.)

ALVARADO PARKWAY INSTITUTE
BEHAVIORAL HEALTH SYSTEM

because you matter!

ADDRESSOGRAPH

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED MEDICAL/PSYCHIATRIC HEALTH INFORMATION

Completion of this form authorizes the disclosure and use of your protected health information (PHI) outside of Alvarado Parkway Institute/BHS (API/BHS). Failure to provide all information requested may invalidate this authorization.

Please read the following information and initial the bottom of this page, then complete the entire second page (Page 2) of this **Authorization to Release/Obtain Protected Medical/Psychiatric Health Information.**

I hereby voluntarily authorize API/BHS to release and disclose my Protected Health Information (PHI), which may include treatment for Physical, Mental Illness, Alcohol/Drug abuse, HIV/AIDS test results and/or diagnoses. I understand when I request information for my own personal use there may be a fee charged to cover any clerical cost. I understand that there may be some documents repetitive in nature excluded from this request, to avoid unnecessary charges. If I have questions regarding excluded documents I will contact API/BHS at 619 667-6013 to discuss my concerns.

This authorization is limited to only the PHI marked for disclosure to the named individual. I agree that a copy or faxed copy of this authorization is as valid as the original. I have the right to make a written request to stop action on this release, but my request may not may have been completed. I understand that I have a right to a copy of this authorization.

I understand my PHI is protected under State and Federal Statutes, Rules and Regulations, including: California Confidentiality of Medical Information Act; California Administrative Code, Title 22; California Welfare and Institutions Code 5328; Title 42 of the Code of Federal Regulations, and Health Insurance Portability and Accountability Act of 1986 (HIPAA), Confidentiality of Alcohol & Drug Records (42 CFR, Part 2) and cannot be disclosed without my written consent. Under federal and state regulations governing the confidentiality of medical, psychiatric, and substance abuse information, API/BHS may not further use or disclose my PHI unless disclosure is specifically required by law.

I understand that once my PHI is disclosed pursuant to this authorization that API/BHS will no longer be able to protect the PHI disclosed and that the recipient of your PHI may not be legally required to protect your PHI. I hereby release API/BHS and its employees for any legal responsibilities or liability that may come from the release of this information. I may refuse to sign this authorization and API/BHS will not withhold treatment or eligibility for benefits based on whether I sign this authorization.

For all outside of API/BHS requests for protected health information to be released this authorization is valid for 90 days (3 months) from the date signed. If this Release of Information form is completed but not acted upon during your stay it will become void at the time of your discharge from API/BHS. For API/BHS Outpatient Services ONLY, this release is valid for one year from date of signature.

Both pages of this form (2 pages) must be submitted *COMPLETED* prior to being processed:

Patient Initial: 1

- **MAIL:** ALVARADO PARKWAY INSTITUTE
  ATTN: Medical Records, 7050 Parkway Drive, La Mesa, CA 91942
- **FAX:** 619-567-4762, **ATTN: ROI Correspondence**

MR – 057 r10/28/19 | Page 1 of 2

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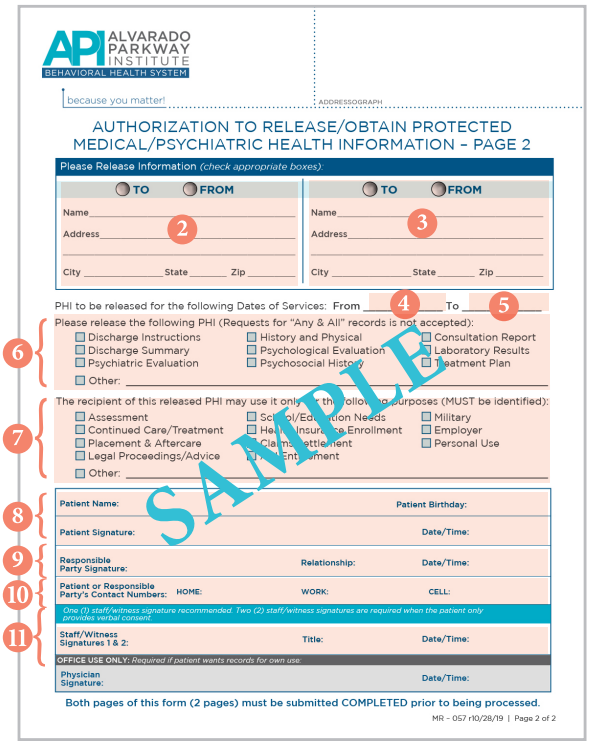
SAMPLE



ALVARADO PARKWAY INSTITUTE
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because you matter!

ADDRESSOGRAPH

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED MEDICAL/PSYCHIATRIC HEALTH INFORMATION – PAGE 2

Please Release Information *(check appropriate boxes).*

TO FROM — Name 2 — Address — City State Zip

TO FROM — Name 3 — Address — City State Zip

PHI to be released for the following Dates of Services: From 4 To 5

6 Please release the following PHI (Requests for "Any & All" records is not accepted):
☐ Discharge Instructions ☐ History and Physical ☐ Consultation Report
☐ Discharge Summary ☐ Psychological Evaluation ☐ Laboratory Results
☐ Psychiatric Evaluation ☐ Psychosocial History ☐ Treatment Plan
☐ Other:

7 The recipient of this released PHI may use it only for the following purposes (MUST be identified):
☐ Assessment ☐ School/Education Needs ☐ Military
☐ Continued Care/Treatment ☐ Health Insurance Enrollment ☐ Employer
☐ Placement & Aftercare ☐ Claim Settlement ☐ Personal Use
☐ Legal Proceedings/Advice ☐ Entitlement
☐ Other:

8 Patient Name: Patient Birthday:
Patient Signature: Date/Time:

9 Responsible Party Signature: Relationship: Date/Time:

10 Patient or Responsible Party's Contact Numbers: HOME: WORK: CELL:

One (1) staff/witness signature recommended. Two (2) staff/witness signatures are required when the patient only provides verbal consent.

11 Staff/Witness Signatures 1 & 2: Title: Date/Time:

OFFICE USE ONLY: *Required if patient wants records for own use.*
Physician Signature: Date/Time:

Both pages of this form (2 pages) must be submitted COMPLETED prior to being processed.

MR – 057 r10/28/19 | Page 2 of 2

SAMPLE

You may submit your **COMPLETED** and **SIGNED** form in the following ways:

- **MAIL:** **ALVARADO PARKWAY INSTITUTE**
  ATTN: Medical Records, 7050 Parkway Drive, La Mesa, CA 91942
- **FAX:** 619-567-4762, **ATTN: ROI Correspondence**
- **DELIVER:** To any API location and request it be forwarded to Medical Records

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