AVIVA HEALTH
150 Kenneth Ford Drive, Roseburg, OR 97470
Phone: 541-672-9596 Fax: 844-870-1183

FROM AVIVA

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION: Completion of this document authorizes Aviva Health to release your protected health information (PHI) to another healthcare provider or entity. Please be sure to provide all information requested. Failure to do so may invalidate this authorization. This authorization expires 12 months after it is signed.

MINORS: The signature of a patient between the ages of 15 and 17 is required to release any of that patient's PHI. The signature of a patient between the ages of 14 and 17 is required to release PHI related to mental illness or alcohol or drug use. The signature of any patient 17 or younger is needed to release PHI related to reproductive care (contraception or pregnancy) or the diagnosis or treatment of sexually transmitted infections.

Patient's Name: _____ Date of Birth: _____

Previous Names: _____ Social Security #: _____

Phone Number: _____

I request and authorize: Aviva Health
To release healthcare information about the above-mentioned patient to:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Purpose: _____

To release and transmit records containing my protected healthcare information (PHI) from Aviva Health 150 NE Kenneth Ford Drive, Roseburg, Oregon 97470. Phone Number: 541-672-9596. Fax Number: 844-870-1183.

By initialing the spaces below, I specifically authorize the release of the following from Aviva Health:

_____ **All Records** (***including*** PHI related to: HIV/AIDS, Mental Health diagnosis and treatment, genetic testing, and SUD/Drug/Alcohol diagnosis, treatment or referral, reproductive care or sexually transmitted infections or diseases).

_____ **All Records** ***except*** information related to (***please initial***):

_____ HIV/AIDS
_____ Genetic testing
_____ Reproductive care
_____ Mental Health diagnosis and treatment
_____ SUD/Drug/Alcohol diagnosis, treatment or referral
_____ Sexually transmitted infections or diseases

OR only the following (***please initial***):

_____ Clinician Office Notes
_____ Diagnostic Imaging Reports
_____ Other (***be specific***) _____
_____ Laboratory Reports
_____ Pathology Reports
_____ Dental Notes
_____ Vaccine Records

Please indicate how much and what kind of SUD information you are authorizing to be disclosed:

_____ By initialing here, I specifically consent to the release of all my SUD diagnosis, prognosis, treatment and referral information.

_____ By initialing here, I wish to limit the release and disclosure of my SUD diagnosis, prognosis, treatment and referral information to the following:

_____

Patient Signature: _____ Date: _____

-- OR--

Legal Representative's Signature: _____ Date: _____

Capacity of Legal Representative: _____

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NOTICE TO SUD PATIENTS: Records containing **SUD (Substance Use Disorder)** diagnosis, prognosis, treatment and referral information is protected by Federal confidentiality rules (42 CFR Part 2). These rules prohibit the use or disclosure of your SUD records, or testimony that describes the information contained in your SUD records, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless you consent to their disclosure and use, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court. In addition, the Federal confidentiality rules prohibit any covered entity or their business associates from making any other use or disclosure of your SUD records unless at least one of the following applies:

- Further use or disclosure is expressly permitted by your written consent or as otherwise permitted by 42 CFR Part 2.
- A covered entity or business associate has received your SUD records for treatment, payment, or health care operations, or
- A covered entity or business associate has received your SUD records from a covered entity or business associate as permitted by 45 CFR Part 164, subparts A and E.

A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the protected records or information contained in them (see 42 CFR 2.31).

YOUR RIGHTS WITH RESPECT TO THE RELEASE OF YOUR PHI

1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization.
2. In the course of providing services or treatment to you, we may need to re-disclose your health information to another healthcare provider or health plan; except for records related to SUD diagnosis, prognosis, or treatment, we cannot guarantee that re-disclosed health information will remain protected by this Authorization or the HIPAA rules or regulations.
3. You may inspect a copy of the protected health information to be used or disclosed;
4. You may refuse to sign this Authorization;
5. We must provide you with a copy of the signed Authorization;
6. You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer Heidi Gallego at 541-672-9596 ext 284.