

**AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I hereby authorize the Marino Center to release health information including copies of my medical records to the following person(s) or facilities at the locations listed for the purpose described:

**Persons/Facility** \_\_\_\_\_

**Address of Location** \_\_\_\_\_

**Purpose** (Check the appropriate box and include a short description):

- At the Request of the Individual / Patient: \_\_\_\_\_
- Continuum of Medical Care: \_\_\_\_\_
- Legal Matter: \_\_\_\_\_
- Insurance: \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

**INFORMATION TO BE RELEASED**

**ENTIRE RECORD**

**OR**

**INDICATE ONLY THOSE RECORDS THAT YOU WANT RELEASED BY CHECKING ALL THAT APPLY WITH THE DATE RANGES NOTED IN THE SPACES PROVIDED:**

- |  |  |
|--|--|
| <input type="checkbox"/> Physician Notes: _____  | <input type="checkbox"/> Lab Results: _____      |
| <input type="checkbox"/> Radiology Report: _____ | <input type="checkbox"/> Operative Report: _____ |
| <input type="checkbox"/> Pathology Report: _____ | <input type="checkbox"/> Other (specify): _____  |

I request the release of the specifically protected or privileged categories of information that I have *INITIALED* below:

\_\_\_\_\_ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)  
**SPECIFY DATE(S):** \_\_\_\_\_

\_\_\_\_\_ Alcohol and Drug Abuse Records Protected by Federal confidentiality Rules 42 CFR Part 2 (FEDERAL RULE PROHIBITS ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR Part 2)

\_\_\_\_\_ Other(s) Please List \_\_\_\_\_

**Confidential Details of:**

- \_\_\_\_\_ Psychotherapy notes (notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling, and that are separate from the medical record)
- \_\_\_\_\_ Other professional services of a licensed psychologist
- \_\_\_\_\_ Social Work Counseling/Therapy
- \_\_\_\_\_ Domestic Violence Victims' Counseling
- \_\_\_\_\_ Sexual Assault Counseling

**Individual or Individual's Personal Representative MUST read and initial the following statements.**

1. INITIALS: \_\_\_\_\_ I understand that the Marino Center will not condition my treatment, (and applicable; payment for my health care, my enrollment in a health plan or eligibility for benefits) on whether I provide authorization for the requested use and disclosure – except in limited circumstances (e.g., if the treatment is research-related or the treatment is necessary for the purpose of creating protected health information for disclosure to a third party such as physical examinations for school, camp, or employment purposes).
2. INITIALS: \_\_\_\_\_ I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (*insert explanation of how to revoke: e.g., on the form provided to me / in a letter*). I understand that such revocation does not affect any action taken by the Marino Center before the Marino Center received my written notice.
3. INITIALS: \_\_\_\_\_ I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.
4. INITIALS: \_\_\_\_\_ I understand that I may see a copy of the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it.
5. INITIALS: \_\_\_\_\_ I understand that this authorization expires on:  
  
\_\_\_\_\_ **or**, \_\_\_\_\_  
(Identify Date (Month, Day, Year)) (Identify Expiration Event)
6. INITIALS: \_\_\_\_\_ I understand that this authorization is voluntary and I have the right to refuse to sign this authorization.
7. INITIALS: \_\_\_\_\_ I understand that The Marino Center will charge me a **\$10** administrative fee plus **\$0.50** per page for the first 100 pages and **\$0.25** per page thereafter for copying services necessary to complete my request, and may include mailing fees if they are extraordinary. Please allow a minimum of 48 hours after payment has been received to process records.

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*Form must be completed before signing*

\_\_\_\_\_  
**Signature of Individual or Personal Representative of Individual**                      **Date**

**Print Name of Individual:** \_\_\_\_\_                      **DOB:** \_\_\_\_\_

**Printed Name of Personal Representative:** \_\_\_\_\_

**Relationship of Personal Representative to Individual:** \_\_\_\_\_

**\*YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION \***