SIDDHARTH SERVICES, INC.

In pursuit of overall well being

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Individual:
Social Security:
Date of Birth:

General Information Regarding This Authorization

This Authorization permits Siddharth Services, Inc to use or disclose your Protected Health Information for purposes of treatment and payment to Siddharth Services, Inc or the health care operations of Siddharth Services, Inc. You have the right to revoke this Authorization by providing Siddharth Services, Inc with written notice or revocation. The revocation will be effective upon receipt by Siddharth Services, Inc except with respect to the use of disclosures made prior to receipt and in reliance upon this Authorization. Siddharth Services, Inc cannot require you to sign this Authorization as a condition to the provision of services.

Authorization

I hereby authorize **Siddharth Services, Inc** or any of its staff to use or disclose, send or receive, by any acceptable means, including fax, or email, my Protected Health Information described as follows:

☐ Medical/dental	☐ Functional/behavioral	☐ Financial
☐ Verbal exchanges	☐ Historical	☐ Program
☐ Psychological/psychiatric	☐ Educational/vocational	☐ Other (reference below)

To/from the following persons or class of persons (include name, address and telephone number):

_____

_____

_____

The Purpose of the requested use and disclosure To receive & provide information relevant to supports & services of Siddharth Services, Inc.

If applicable, please initial the appropriate blank in the following two statements:

1. *Alcohol/Drug Treatment Records.* I do ____ / I do not ____ authorize the use or disclosure of drug or alcohol abuse treatment records. I understand that these records are protected under federal regulations (42 CFR Part 2). I understand that I have the right to refuse to release this information. If alcohol or drug abuse treatment records are disclosed, the following notice shall be included with the records:

> **"This information has been disclosed to you from our records and is 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 written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. "**

2. HIV Status. I do ____ / I do not ____ authorize the release of HIV test results for the purpose set forth above.

This Authorization shall expire on , which is no more than one year after its effective date, unless it is revoked prior to the expiration date.

_____ _____
Signature of Individual or Legal Guardian Signature of Witness

_____ _____
Print Name of Individual or Legal Guardian Print Name of Witness

_____ _____
Date Date