HELP-US HELP-U, INC. *d/b/a UNIFY Health & Wellness*

FORM 2 AUTHORISATION TO DISCLOSE RECORDS

Complete only when records must move to or from an outside party. One form per provider or person. If a question does not apply, or the information is not available, write NA.

Patient name		Date of birth
Client ID	**Date**	**Staff**

1. RELEASED FROM

Individual or facility	Phone
Address	**Fax**

2. RELEASED TO

Individual or facility	Phone
Address	**Fax**

Where HUHU is requesting records on the patient's behalf, they are sent to Help-Us Help-U, Inc., 641 49th Street N, St. Petersburg, FL 33710, fax (727) 478-6009.

3. PURPOSE AND METHOD

☐ Continuity of care ☐ Personal use ☐ Insurance or benefits ☐ Legal ☐ At patient's request ☐ Other

☐ Paper ☐ Fax ☐ Secure email ☐ Collected in person

4. WHAT MAY BE SHARED — TICK EVERY ITEM AUTHORIZED

Dates of service, optional	From date	To date

☐ Progress notes ☐ Immunization records ☐ Medication list ☐ Laboratory results ☐ Radiology results
☐ Discharge summaries ☐ Operative or procedure notes ☐ Research or study notes ☐ Other

☐ Abstract medical records for the last twelve months of treatment

5. PROTECTED RECORDS — INITIAL ONLY WHAT IS AUTHORIZED

A general authorization is not sufficient for substance use records. Each category below must be initialed separately.

Initial: _____	**HIV or AIDS records.**

Initial: _____	**Substance use disorder or medication assisted treatment records.**

Initial: _____	**Mental health or behavioral health records, other than psychotherapy notes.**

Initial: _____	**Sexually transmitted infection records.**

Initial: _____	**Genetic information or testing.**

Initial: _____	**Family planning records.**

Initial: _____	**Sexual assault records.**

Psychotherapy notes are not covered by this form. They require their own authorization, on Form 2A, which cannot be combined with any other form.

FORM 2 AUTHORISATION TO DISCLOSE RECORDS (continued)

6. HOW LONG THIS LASTS

This authorization expires twelve months from the date signed, unless a different date or event is set below.

Different expiry date	Or the event that ends it

7. NOTICES

This release may include sensitive information: mental and behavioral health, genetic testing, HIV and AIDS, sexually transmitted infections, family planning, substance use disorder, and sexual assault. Signing this authorizes that information to go to the recipient named above. Signing is voluntary and care will not be denied or affected by refusal. The patient may cancel it at any time by writing to the Privacy Officer; cancellation does not undo anything already done in reliance on it. The patient is entitled to a copy of this signed form and may request a list of disclosures made on their behalf at any time. Information released may be passed on by the recipient and may then no longer be protected by federal privacy rules; information covered by the federal substance use disorder rule may not be passed on at all.

Notice to whoever receives this: use or disclosure of this information for a purpose prohibited by the federal privacy rule at 45 C.F.R. 164.502(a)(5)(iii) may carry criminal penalties under 42 U.S.C. 1320d-6. This information may come from records protected by federal substance use confidentiality rules and may not be passed on further without the patient's written consent or as those rules otherwise allow. A general medical release is not enough, and this information may not be used to investigate or prosecute a patient for a substance use disorder.

Patient / representative signature	Date

Printed name	Relationship to patient	Witness (optional)

8. WITHDRAWAL — COMPLETE ONLY IF CANCELLING

Date cancelled	Signature	Witness