AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section 1: Purpose of the Use or Disclosure of Protected Health Information

The purpose of this Authorization for Use and Disclosure of Protected Health Information is to allow health care providers to disclose protected health information to Solari so that the Solari may evaluate my eligibility to receive Serious Mental Illness (SMI) services or Serious Emotional Disturbance (SED) services. Federal and state law prohibits health care providers from sharing my health information without my permission except in certain situations. By signing this Authorization, I am giving permission for my health care providers to share my health information with Solari.

Section 2: Applicant whose Health Information is to be Used or Disclosed

Last Name		First Name		Middle Initial			
Social Security Number		Date of Birth (MM/DD/YYYY)		Phone Number (with area code)			
Address		City		State		Zip Code	

Section 3: Providers Directed to Use or Disclose Protected Health Information

Healthcare Provider Name		Phone Number (with area code)	
Address		City, State, and Zip Code	

Healthcare Provider Name		Phone Number (with area code)	
Address		City, State, and Zip Code	

Healthcare Provider Name		Phone Number (with area code)	
Address		City, State, and Zip Code	

[insert additional sheets if necessary]

Section 4: Health Information to be Used or Disclosed

I hereby authorize the use and disclosure of my health information needed to evaluate my eligibility to receive Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) services. **In addition to my general medical record information (e.g., prescriptions, consultations, provider notes, hospital records, etc.), I understand that this may include disclosure of my mental health, behavioral health, alcohol and other drug abuse treatment, and developmental disability information, including diagnosis, treatment plans, prognosis, and medication(s).**

Further, I authorize the use and disclosure of my:

HIV-related information: ☐ **YES** ☐ **NO**

Other communicable disease related information: ☐ **YES** ☐ **NO**

Genetic information: ☐ **YES** ☐ **NO**

For The Following Date(s): _____

Section 5: Expiration of this Authorization

This Authorization will remain effective for **one year** from the date it is signed unless I designate a specific expiration date, event, or condition here: _____

Section 6: Revocation of this Authorization

understand that I may revoke this Authorization at any time by writing to Solari at 1275 W. Washington, Suite 201, Tempe, Arizona 85288. The revocation will be effective except to the extent that Solari has already used or disclosed my health information in reliance on this Authorization.

Section 7: Rights and Notices

I understand the following:

- Signing this Authorization is voluntary. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.
- My information disclosed pursuant to this Authorization is subject to redisclosure by the recipient and may no longer be protected by the terms of this Authorization or by federal and state privacy regulations. All disclosures of my health information protected by federal regulation 42 CFR Part 2 will be accompanied by a notice informing the recipient that redisclosure of the information is prohibited except as permitted by law.
- I must be provided a copy of this signed Authorization.

Section 8: Authorization of Applicant/Legal Representative

_____ _____

Applicant Signature Date of Signature

_____ _____

Legal Representative Signature (if applicable)* Date of Signature

If signed by a Legal Representative, complete the following:

1. The Applicant is: □ a minor □ legally incompetent or incapacitated □ deceased
2. Legal authority: □ parent □ legal guardian □ next of kin/executor of deceased
   □ activated POA for health care

* If Applicant is under 18 years of age, both his/her signature is preferred along with required signature of parent/legal guardian.