Serenity Health LLC

HIPAA Privacy Authorization Form

I, _____ _____

Patient's First and Last Name — Patient's Date of Birth

_____

Patient's Full Address (include city, state and zip code)

_____

Patient's Social Security Number — Patient's Telephone Number — Patient's Email Address

I Authorize Serenity Health, LLC at the following office(s):

	Location	Address	City, State, Zip	Telephone	Fax
	South County	5000 Cedar Plaza Parkway, Ste 350	St. Louis, MO 63128	314-590-3721	314-214-7380
	St. Peters	4905 Mexico Road, Ste 400	St. Peters, MO 63376	314-590-3721	314-214-7380
	West County	11477 Olde Cabin Road, Ste 210	St. Louis, MO 63141	314-590-3721	314-214-7380

I Authorize Serenity Health, LLC to □ Obtain from or **□ Release To:**

Name (agency, provider, etc) **Telephone Number** **Fax Number**

Full Address (include city, state, and zip code)

For the purpose of □ Release or □ Exchange:

Specify information to be released and/or exchanged

I permit the release of all information indicated above including, if any, information concerning mental health, drug/alcohol treatment or use, AIDS/HIV and other communicable diseases, test results and/or diagnosis or treatment.

I understand that my records are protected under Federal (42 CFR, Part II) and State Confidentiality Regulations. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing at any time, except the extent that action has been taken in reliance upon this authorization. This release of information expires in one hundred and twenty days (120) or _____*(enter date)* following completion or termination of treatment. I further acknowledge that the information to be released was fully explained to me and this authorization is given on my own free will.

Executed on the following date: _____(mm/dd/yyyy)

Patient Signature	
Representative Signature *if applicable*	
Witness Signature	

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part II) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. *A general authorization for the release of medical or other information is not sufficient for this purpose*. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.