Standard Authorization Form

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information is Section I may result in the ability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*

FORM A - AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

Section I

First Name*	M.I.	Last Name*	Date of Birth*	Social Security Number
Mae	L.	Blossom	11/7/1989	440-15-3700

Address	City	State	Zip Code
4337 Half and Half Drive	Fresno	California	93706

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

Disclosing Entity* *(Covered Entity such as a health plan/insurer or provider)*
Mercy Health - St. Joseph Warren Hospital

Address	Telephone Number
667 Eastland Ave.	330-841-4000

City	State	Zip Code
Warren	Ohio	44484

Recipient (Person or Entity)*
Mae L. Bloom

Contact Information *(E.g. telephone number, email address, fax number, street address, etc)*
209-978-5368

Section III

Reason for Disclosure*
at my request

Health information to be disclosed*:
HIV/AIDS result
Drug test Result

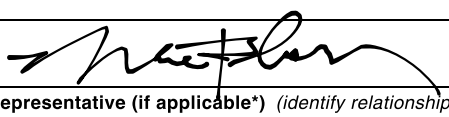
Specify time period, if desired:
Release only information from the period 6 months *(mm/dd/yyyy)* to 12/30/2023 *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event 209-978-5368 *(mm/dd/yyyy)*

- I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

Signature of Individual*	Date* *(mm/dd/yyyy)*
	June 2, 2023
Signature of Personal Representative (if applicable*) *(identify relationship to individual below)* n/a	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Indivual *(Personal representative shall submit proof of authority to the disclosing entity)*

☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other ☑ N/A

For administrative use only:

Method of Delivery (E.g. paper, fax, electronic)	Date Released
Electronic	June 4, 2023

FORM B - CONSENT FOR RELEASE OF PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION

At Part 2 Program is a federally assisted: (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment, or referral for treatment; (ii) an identified unit within a general medical facility that holds itself out as providing, and provides SUD diagnosis, treatment, or referral for treatment; or (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment, and who are identified as such providers.

Section I

First Name*	M.I.	Last Name*	Date of Birth*	Social Security Number
Mae	L.	Bloom	11/7/1989	440-15-3700

Address	City	State	Zip Code
4337 Half and Half Drive	Fresno	California	93706

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

Disclosing Entity* *(Covered Entity such as a health plan/insurer or provider)*	Telephone Number
Mercy Health - St. Joseph Warren Hospital	209-978-5368

Address	City	State	Zip Code
667 Eastland Ave.	Warren	Ohio	44484

The information is to be provided to the following*:

- [x] Named Individual:
- [x] Named Third Party Payer:
- [ ] Named Treatment Provider Entity:
- [ ] Named Non-Treatment Provider (such as an intermediary or research entity)+

+ If non-treatment provider is selected complete a, b and/or c below.

a. Named Individual Participant(s): Mae L. Bloom

b. Named Treatment Provider Entity Participant(s): Mercy Health - St. Joseph Warren Hospital

c. Description of Group or Class of Treatment Provider Entity Participant(s): Hospital

Contact Information *(E.g. telephone number, email address, fax number, street address, etc)*
559-838-5077

Section III

Reason for Disclosure*	Health information to be disclosed*:
at my request	Drug Test Results

Specify time period, if desired:

Release only information from the period 6 Months *(mm/dd/yyyy)* to 12/30/2023 *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event _____ *(mm/dd/yyyy)*

- Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient.
- I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services.
- If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation.

Signature of Individual*	Date* *(mm/dd/yyyy)*
	06/02/2023
Signature of Personal Representative (if applicable*) *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Indivual *(Personal representative shall submit proof of authority to the disclosing entity)*

- [ ] Parent
- [ ] Legal Guardian
- [ ] Healthcare Power of Attorney
- [ ] Executor/Administrator
- [ ] Other
- [x] N/A

For administrative use only:

Method of Delivery (E.g. paper, fax, electronic)	Date Released
Electronic	June 4, 2023