AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Covered entities, as that term is defined by HIPAA, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law.

Individuals completing this form should read the form in its entirety before signing and completing all the sections that apply to their decisions relating to the disclosure of their protected health information.

INDIVIDUAL'S INFORMATION:
Full Name: _____
Other Name(s) Used: _____
Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Email (*Optional*): _____

I AUTHORIZE THE FOLLOWING TO RECEIVE, USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FROM/TO ONE ANOTHER:

Name: Allies Against Slavery
Address: P.O. Box 684284 **City:** Austin **State:** Texas **Zip Code:** 78768
Phone: (_____) _____ **Fax:** (_____) _____

Name: **[INSERT PARTNER ORGANIZATION INFORMATION]** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Phone: (_____) _____ **Fax:** (_____) _____

SPECIFIC INFORMATION TO BE DISCLOSED:

□ **All health information**, including name, date of birth, geographical elements, digital identifiers, and all of the below listed information, ***to the extent applicable***.

□ Patient histories, allergies, past/present medications, referrals, and consults
□ Lab results and diagnostic reports
□ Billing records, insurance records, and any other records received from health care providers
□ Other: _____

Include *(to the extent applicable)*:	**Reason for release of information *(choose all that apply)*:**
(*Indicate by Initialing*)	
_____ Drug, Alcohol or Substance Abuse Records	□ Treatment/Continuing Medical Care
_____ Mental Health Records (Except Psychotherapy Notes)	□ Personal Use
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)	□ Billing or Claims
	□ Insurance
_____ Genetic Information (Including Genetic Test Results)	□ Legal Purposes
	□ Disability Determination
	□ School
	□ Employment
	□ Other *(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the individual for whom this authorization is made or the individual revokes the authorization.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the organization, entity, or individual listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. **I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.**

SIGNATURES:

Individual/Legal Representative*:_____ Date:_____

If Legal Representative, relationship to Individual: _____

*A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Allies Against Slavery ("Allies") operates an information database and platform, hereafter referred to as ("Lighthouse,") for the purposes of identifying signs of and supporting responses to human trafficking. Specifically, Allies may collect, receive, disclose, or otherwise process your personal information, including with our third party partners who access Lighthouse, in order to:

- Enter information into Lighthouse;
- Facilitate better support coordination, efficiency, and development of services;
- Enhance strategic planning between agencies, government entities, and non-profit organizations; and
- Assist with resource allocation and increase opportunities for victim identification.

The authorization provided by use of this form means that Allies can receive from **and** disclose, communicate, or send your protected health information to the organization, entity or person identified on the form, including through the use of any electronic means. Permission to receive and disclose protected health information also includes Allies' **and** that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form.