AllaraCare

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name	Date of Birth	Daytime Phone Number
_____	_____	_____

I authorize AllaraCare Medical Group

TO: ❑ **Send/Disclose information to:** ❑ **Receive information from:** ❑ **Discuss with:**

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

For the following purpose(s): ☐ Consultation ☐ Provider Transfer ☐ Personal ☐ Insurance ☐ Worker's Compensation ☐ Legal/Attorney ☐ School

☐ Other: _____ **Request for Decedents Information:** Date of Death: _____

Type of information requested:

☐ Complete Record	☐ Immunizations	☐ Office/Progress Note(s)
☐ Consultations	☐ Inpatient Information	☐ Operative Report
☐ Discharge Summary	☐ Itemized Billing Records	☐ Outpatient Information
☐ ER Report(s)	☐ Laboratory Report	☐ Radiology Report(s)
☐ History & Physical	☐ Medication Records	☐ Other _____

Dates of care to be released: _____to_____

I UNDERSTAND THAT:

- A fee for the cost of processing this request may be charged. At your request, we will provide you a copy of this form.
- I understand that my healthcare will not be affected if I do not sign this form.
- I hereby authorize AllaraCare Medical Group to use/disclose my individually identifiable health information as described below (which may include photographs and/or information concerning treatment for drug/alcohol abuse, mental health, HIV/AIDS status, or genetic testing, if applicable).
- I understand that if the recipient authorized to receive the information is not a covered entity, such as insurance company or health care provider the disclosed information may no longer be protected by federal and state privacy regulations and may be re-disclosed.
- AllaraCare Medical Group may utilize a trusted business associate/authorized agent to assist in fulfilling this request.
- I can revoke this authorization at any time by submitting a request in writing to the Medical Records department at AllaraCare Medical Group. This will not apply to any previously released information.
- This authorization expires one year from the date of signature, or on: _____.

The following information WILL BE RELEASED unless indicated by your initials below:

Initials: _____ Drug and/or alcohol treatment	**Initials: _____ Sexually transmitted disease**
Initials: _____ Mental health treatment	**Initials: _____ Genetic testing**
Initials: _____ HIV/AIDS	

_____ _____

Signature of Patient or Legal Representative/Guardian Date

A parent or guardian is generally required to sign for a patient under the age of 18. Patients age 12 to 17 may also be required to sign.

_____ _____

Printed Name of Patient/Legal Representative Authority or Relationship of Representative (Attach copy of documentation of authority)

This information may contain information relating to drug and alcohol treatment that is protected by Federal confidentiality regulations (42 CFR Part 2). Federal regulations 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 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient**.** 42 CFR § 2.51 (a) Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

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