Release of Confidential Health Information

Patient name: ____________________________________ Telephone: ___________________________
Address: ____________________________________ Date of birth: ___________________________
City/State/Zip: ____________________________________

I hereby authorize the protected health information regarding the above-named person to be exchanged to:
Person/Institution/Other: ____
Address: ___________________________________ City/State/Zip: ______________________________

I authorize the release of information pertaining to the following time periods:
From date(s): __________________ To date(s): _________________ OR All dates of Service __________

The following types of information to be disclosed are as follows:

☐ Entire Medical Record ☐ Billing Records ☐ Other _____________________________________

I understand that the information in my health record may include information relating to HIV/AIDS, Behavioral or mental health, Drug/alcohol diagnosis, treatment, referral information, and Genetic testing.

Method of Delivery:

☐ Pick up CD in office
☐ Mail CD to _______________________________________
☐ Fax to ____
☐ Email to ____

• By providing an email address I understand that I may receive Protected Health Information (PHI) and/or sensitive information such as name, address, and types of medical records requested via standard (unencrypted) email and that there is risk of disclosure or interception of these emails.

The purpose(s) of this authorization is: ____

This authorization expires (date):_________________. If not specified, this release will expire 1 year after the date of signature: _____________

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclosure my health information. Written revocation must be sent to the physician's office.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize **UrbanCare, LLC** to use or disclose my health information in the manner described above.

Printed name of patient, legal guardian, or authorized agent: ______________________________
Signature of patient, legal guardian, or authorized agent: _________________________________
Date:________________________ **Relationship to patient:**_________________________________