HIPAA Compliant Authorization for Release of Patient Information Pursuant to 45 CFR 164.508

Section I – Patient Information

Name:		Member ID:
Street Address:		Birth Date:
City:	State:	Zip:
Telephone:	Email:	

I, or my authorized representative, hereby authorize Freedom Health and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to the designee identified below.

SECTION III –Authorized Designee (to whom the information will be sent)

Name:		Relationship:
Street Address:		Telephone:
City:	State:	Zip:

In accordance the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION** only if I place my initials on the appropriate line in Section III. In the event the health information described below includes any of these types of information, and I initial the line on the box in Section III, I specifically authorize release of such information to the person indicated in Section II.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization
3. I have the right to revoke this authorization at any time by writing to Freedom Health. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in Freedom Health, or eligibility benefits will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient, and the redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY PERSONAL HEALTH INFORMATION AND INSURANCE RECORD WITH ANYONE OTHER THAN THE PERSON AUTHORIZED IN SECTION II.**

Section III – Specific Information to be Released:

☐ Please release my Medical Record from (insert date) ____________ to (insert date) ____________.

☐ Please release my entire Medical Record, including patient histories, office notes (excluding psychotherapy notes, test results, radiology studies, films, referrals, consults, billing records, insurance records sent to Freedom Health by health care providers.

☐ Other: (please explain) _________________

____

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☐ Include: (Indicate by Initialing)

______ Alcohol/Drug Treatment

______ Mental Health Information

______ HIV-Related Information

Reason for release of information:

☐ At the request of the individual

☐ Other: ____

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:

Date or event on which this authorization will expire: ____

If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

AUTHORIZED REPRESENTATIVE

<table>
<tr><td colspan="2">Name:</td><td>Relationship:</td></tr>
<tr><td colspan="2">Street Address:</td><td>Telephone:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td></tr>
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By signing this form, I am confirming that it accurately reflects my wishes. In addition, I have kept a copy of this form for my records.

____   ______________________

Signature of Member or Authorized Representative   Date