AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf, to release the health information for:

PATIENT NAME: Date of Birth:

Name of Health Care organization or Physician

Information is to be released from records pertaining to:
☐ Ambulatory ☐ Inpatient ☐ Emergency Department ☐ Other _____

For date(s) of service: _____

Specific Information to be Released:

☐ Complete medical record	☐ Radiology
☐ Laboratory tests	☐ Cardiac tests
☐ Alcohol/Substance Abuse	☐ AIDS/HIV
☐ Mental Health	☐ Psychotherapy Notes

Other (specify) _____

Information is to be released to:

_____

_____

_____

_____

Information is to be released for the purpose of treatment and continuity of care.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare' compliance with this request. The revocation must be in writing and is subject to terms described in AtlantiCare Notice of Privacy Practices and other AtlantiCare policies.

I understand that I am not required to sign this authorization and that AtlantiCare may not condition treatment or services on my execution of this authorization.

I understand that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA.

This authorization will expire upon the release of the information described above or one year (12) months after the date of the authorization, unless specified otherwise. Expiration date: _____

_____

Signature of Patient or Personal Representative Date

Personal Representative's relationship to Patient: _____

Patient is unable to sign because_____

Updated 04/01/2014 IV

Patient is entitled to a copy of signed authorization.