AUTHORIZATION FOR RELEASE OF INFORMATION FROM HEARTPLACE

1. I hereby authorize HeartPlace to release and transfer to:

_____

(Doctor, Hospital, Attorney, etc.)

_____

Street Address City/State Zip Code

the following information from its records on :

_____

(Patient's Name)

_____ _____

Birth Date Social Security Number

SPECIFY INFORMATION:

2. The above information is released for the following purpose and that purpose only. **Other uses are prohibited.**

_____

_____

3. I understand that the specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of this specific data.

4. I understand that I may revoke this Authorization at any time by notifying HeartPlace in writing, but if I do, it will not have any effect on any actions HeartPlace took, including any uses or disclosures of my Protected Health Information made by HeartPlace, before it received the revocation of this Authorization.

5. I understand that if my Protected Health Information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.

6. I understand that I have a right to inspect and copy my own Protected Health Information to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C.F.R. 164.524).

7. I authorize faxing the information to be disclosed to the requesting party. ☐ Yes ☐ No

8. I have read and understand this consent and I have signed it voluntarily and of my own free will.

9. This authorization will expire ninety (90) days from the date of signature.

_____ _____

Signature of Patient Witness

_____ _____

Specify Relationship (legal & authorization where applicable) Witness

_____ _____

Date Date

PROHIBITION ON REDISCLOSURE: The following information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit the redisclosure of the information without the written consent of the person to whom it pertains unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.

I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by HeartPlace to provide the copies requested.

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