CenterWell
Senior Primary Care

Authorization to Release or Request Protected Health Information

PATIENT INFORMATION:		
Last Name:		First Name:
Address:		
City:	State:	Zip Code:
Phone Number:	Date of Birth:	

NAME OF PROVIDER OR HEALTHCARE FACILITY RELEASING INFORMATION:		
Provider:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax:	

From: ____/____/____ To: ____/____/____ ☐ All past and future Dates
Start Date End Date

NAME OF PROVIDER OR HEALTHCARE FACILITY REQUESTING INFORMATION: [SEND TO]		
Provider:		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax:	

From: ____/____/____ To: ____/____/____ ☐ All past and future Dates
Start Date End Date

SIGNATURE REQUIRED:

I understand that by signing and submitting this form, I am authorizing the name of the clinic below to receive or release my complete heath records, including the following:

_____
Name of Clinic

- **My complete health records including:**
  - ☐ Mental Health
  - ☐ HIV or AIDS
  - ☐ Communicable diseases
  - ☐ Treatment of alcohol/drug abuse
  - ☐ Diagnosis, lab tests, prognosis, treatment, and billing for all condition
- **For the purposes of:**
  - ☐ Medical Treatment or consultation
  - ☐ Billing or claims payment
- **Other purposes as I may direct:** _____

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I understand the following:

♦ This authorization is valid for the information already in existence and any information that may be generated while this authorization is effective.	♦ The revocation will **not** apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
♦ I have the right to see any information that is disclosed pursuant to this authorization for release and I may request to see this information during normal business hours.	♦ Authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization. ♦ I need not sign this form in order to assure treatment, payment or eligibility for services.
♦ I can revoke my authorization at any time and that the revocation will not apply to information that has already been released in response to this authorization.	♦ If the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential.

Unless otherwise revoked, this authorization shall expire **12 months** following the date of signature.

I acknowledge that I have read this form or it has been read to me and I understand its content.

Print Name _____ Date _____

Signature _____

Name of Interpreter/Translator (if required) _____ Phone Number _____

OFFICE USE ONLY

Office Personnel (Print Name) _____ Date _____

Office Personnel Signature _____