

CenterWell ACE
Authorization for Release and Disclosure of Protected Health Information
(Person or Organization)

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Patient Email: _____
Home Phone #: _____ Cell Phone #: _____

This form may be used to authorize the release and disclosure of protected health information (“PHI”) FROM CenterWell ACE entities, including CenterWell Senior Primary Care, Conviva Care Center, and Elite Health Medical Centers (collectively, “CenterWell”), to a specific person or organization. (Use separate authorization for healthcare providers and entities).

I AUTHORIZE THE FOLLOWING TO DISCLOSE MY PHI:

Provider Organization: _____
(CenterWell Senior Primary Care, Conviva Care Center, or Elite Health Medical Centers)

Clinic Name: _____ Phone #: _____

THE FOLLOWING MAY RECEIVE MY PHI FROM CENTERWELL:

Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Relationship: _____ (spouse, friend, sibling, attorney, etc.)

HEALTH INFORMATION TO BE RELEASED – Please read carefully

I understand that this authorization form may allow the release, use or disclosure of my protected health information (“PHI”), which includes PHI collected and maintained by CenterWell Senior Primary Care and its affiliates, information on health treatment programs, plan information, and caregiver resources. I understand and affirm that by checking any box below and signing this form, I give my express and informed consent for the release of all sensitive information and related treatment records which may be contained within these records, including but not limited to: sexually transmitted diseases; communicable diseases; HIV/AIDS, including test results and treatment; substance, alcohol, and/or drug abuse; mental and behavioral health (excluding psychotherapy notes), genetic information/testing; and other related conditions.

Indicate below the PHI that you want disclosed. If all information is to be released, then only check the first box.

- Complete Disclosure.** Release my complete record set, including, without limitation, clinical records, plan information/claims data, and outside records/referrals (from or to other providers, specialists, or treatment centers).
- Limited Disclosure.** Do not release my complete record set; release only the items or information checked below:
- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Immunizations/Vaccines | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Pharmacy/Prescriptions | <input type="checkbox"/> Orders |
| <input type="checkbox"/> Insurance/Claims Data | <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Procedures | <input type="checkbox"/> Labs |
| <input type="checkbox"/> Outside Records/Referrals (from or to other providers or treatment centers) | | | <input type="checkbox"/> Imaging (x-rays, EKG, etc.) |
| <input type="checkbox"/> Other (describe): _____ | | | |

PURPOSE: The purpose of this authorization to release information is at the request of the individual authorizing disclosure. If the authorization is for a purpose other than that stated above, please specify: _____

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the patient, or in **36 months** from the date of signature.

I UNDERSTAND THAT:

- I can withdraw my permission at any time by giving written notice to CenterWell, stating my intent to revoke this authorization.
- Signing this authorization is voluntary. Treatment, payment, enrollment, or eligibility decisions will not be conditioned upon my decision to sign this authorization form, except as authorized by federal privacy regulations.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and may no longer be protected by federal or state privacy laws.
- Refusing to sign this form does not stop disclosure of protected health information that is otherwise permitted by law without my specific authorization or permission.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses, releases, and disclosures of my protected health information as described.

Signature of Patient or Patient’s Legally Authorized Representative* Date

Printed Name of Legally Authorized Representative (if applicable) Date

*If representative, describe your authority to act for this individual and provide any corresponding documentation (guardian, power of attorney, healthcare surrogate, etc.): _____