CenterWell ACE

Authorization for Release and Disclosure of Protected Health Information (Healthcare Providers & Entities)

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 healthcare provider or entity, or to an entire class of healthcare providers & entities. Alternatively, the form may be used to authorize the release and disclosure of PHI TO CenterWell from a specific healthcare provider or entity, or from an entire class of healthcare providers & entities.

I AUTHORIZE THE FOLLOWING TO DISCLOSE MY PHI:
Check one box only

☐ Any physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other healthcare provider that has provided payment, treatment, or services to me or on my behalf.

OR

☐ The following healthcare provider or entity:
Name: _____ Phone #: _____
Fax #: _____ Address: _____
City: _____ State: _____ Zip: _____

THE FOLLOWING MAY RECEIVE AND USE MY PHI
Check one box only

☐ Any physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other healthcare provider that has provided payment, treatment, or services to me or on my behalf.

OR

☐ The following healthcare provider or entity:
Name: _____ Phone #: _____
Fax #: _____ Address: _____
City: _____ State: _____ Zip: _____

DISCLOSE MY PHI FROM:
Check one box only

☐ All past and future dates **OR** ☐ From: _____ (Start Date) to _____ (End Date)

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"), including PHI collected and maintained by the provider(s) or entity(ies) identified above, 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:

- ☐ Immunizations/Vaccines
- ☐ Progress Notes
- ☐ Pharmacy/Prescriptions
- ☐ Orders
- ☐ Insurance/Claims Data
- ☐ Treatment Plans
- ☐ Procedures
- ☐ Labs
- ☐ Outside Records/Referrals (from or to other providers or treatment centers)
- ☐ Imaging (x-rays, EKG, etc.)
- ☐ Other (describe): _____

PURPOSE: The purpose of this authorization is for treatment/continuing medical care, payment, or health care operations. 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, including disclosures to covered entities as provided by state law or by 45 C.F.R. 164.502(a)(1).

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.): _____