**AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION**

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Health Insurance Portability and Accountability Act (HIPPA).

*All items on this authorization must be completed in full, for the request to be valid.*

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| **I hereby authorize (the following facility to release the protected health information:**  **Facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_  The information is to be released to:  **Referring Provider/PCP:** Continuum Wellness Center LLC  **Address:** 2 West Rolling Crossroads, Ste 111 Catonsville, MD 21228  **The information I wish to have released:**  ☐ H&P ☐ Laboratory Report ☐ Discharge summary ☐ Other |

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| **I hereby authorize (Continuum Wellness Center LLC) to release the protected health information of:**  **Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_  The information is to be released to:  **Referring Provider/PCP:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **The information I wish to have released is**  ☐ Consultation Report ☐ Discharge summary ☐ Therapy Notes ☐ Other  ☐ I do ☐ I do not wish to have information about HIV/AIDS released under this authorization.  ☐ I do ☐ I do not wish to have mental health records released under this authorization.  ☐ I do ☐ I do not wish to have information about drug/alcohol abuse treatment released under |

*This authorization will expire one year from the date it is signed unless a shorter time is indicated here:*

I understand:

* This authorization is voluntary.
* My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
* I may receive a copy of this form.
* I may inspect my protected health information without signing this form.
* This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke this authorization, I understand that I must notify Continuum Wellness Center LLC in writing.
* I understand that once information covered by this authorization has been disclosed redisclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by state law.

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Patient’s Signature Date

If signature is other than patient, explain your authority to act for the patient:

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Personal Representative’s Signature Date

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Witness’s Signature

Date