advocare

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I authorize Advocare, LLC to disclose the following information from the medical records of:

Patient Information:
(Print) Patient Name:_____ Date of birth:_____

Address:_____

Phone Number:_____ Patient SS#:_____

Covering the period(s) of health care: From: _____ To: _____

Information to be disclosed:

☐ Complete health record(s), excluding all images **OR**

Select from the following (check all which apply):

☐ Discharge Summary
☐ History and Physical Examination
☐ Consultation Reports
☐ Mental health care or services
☐ Progress Notes
☐ Laboratory Tests
☐ X-ray reports
☐ Photographs, videotapes, digital or other images
☐ Treatment for alcohol and/or drug abuse
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
☐ Other (please specify):_____

This information is to be disclosed to the individual or entity identified below for the purpose of:

_____

Release Records To:

Name:_____ Relationship:_____

Address:_____
Phone Number:_____

Patient or Patient's Legal Representative must read and initial the following statements:

1. I understand that unless earlier revoked, this authorization expires on __/__/20__ or on the happening of _____. ***Initials: X _____***

2. I understand that I may revoke this Authorization at any time by notifying Advocare, LLC in writing, but if I do so my revocation will not have any effect on any actions Advocare, LLC took in reliance on this Authorization before it received my revocation. ***Initials: X _____***

3. I understand that Advocare, LLC cannot make me sign this Authorization as a condition to receive treatment from Advocare, LLC:
   i. When Advocare, LLC provides me with research related treatment; or
   ii. When Advocare, LLC provides me with health care solely for the purpose of creating protected health information for disclosure to someone else. ***Initials: X _____***

Advocare, LLC, its providers, employees, members and agents are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(*Form MUST be completed before signing*)

Signature of Patient or Legal Representative: _____
Print Name: _____ Dated: _____
If Signed by Legal Representative, state relationship to Patient: _____

Note: If you are the Patient's Legal Guardian other than a parent, or if you are the Patient's Power of Attorney, a copy of the legal document granting you such power must be attached to this request.