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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

For oral communications, please complete the *Avance Care Consent to Verbally Disclose PHI* form

This authorization applies to the entire Avance Care organization, including all primary care services, and behavioral health and wellness specialties.

Section One: Patient Information	
I give permission to release the health information of:	
LEGAL PATIENT NAME (REQUIRED)	DATE OF BIRTH
ADDRESS	PHONE
EMAIL ADDRESS	MEDICAL RECORD NUMBER (if known)
LEGAL REPRESENTATIVE NAME (*IF NOT PATIENT)	RELATIONSHIP TO PATIENT (Parent, Guardian, or Authorized Representative)
*If you are not the patient or the parent of a minor patient, you MUST attach documentation of your authority to act on behalf of the patient (Healthcare Agent/Power of Attorney, Court Order, Legal Guardian Documentation, Executor/Administrator Documentation)	
Section Two: Disclosing and Receiving Parties	
Release my records FROM:	
Avance Care (Please list individual location(s) or indicate "All") _____ OR	
Name/Facility and/or Practice _____	Phone: _____
Address: _____	Fax: _____
Release my information TO:	
Me, using the contact information above, in the format specified in Section Five.	
OR Name/Facility and/or Practice _____	Phone: _____
Address: _____	Fax: _____
Section Three: Scope of Disclosure, Information to be Released	
Treatment Dates to include:	
All treatment dates OR Dates of service: _____ to _____ only (please be specific)	
----- Please read this section carefully -----	
<input type="checkbox"/> Entire Medical Record , to include all categories listed below, OR Individual Categories: <ul style="list-style-type: none"> <input type="checkbox"/> Behavioral health/mental health records* <input type="checkbox"/> Psychiatry records <input type="checkbox"/> Lab/pathology reports <input type="checkbox"/> Immunization records <input type="checkbox"/> Allergy notes <input type="checkbox"/> Procedure notes <input type="checkbox"/> Imaging reports <input type="checkbox"/> Nutrition notes <input type="checkbox"/> Medication list <input type="checkbox"/> Other: _____ 	AND/OR Billing statements (not typically included as part of your medical record) ----- All types of information found in the records selected to the left will be provided (if applicable), including information that may be viewed as sensitive, such as information related to substance abuse disorder (SUD), genetic information, HIV testing, HIV results or AIDS information . If you do NOT want these categories included in this release, you must clearly indicate that choice here. Please specify any information you want to <u>exclude</u>: _____ _____
* This release does not include psychotherapy or SUD counseling notes that are maintained separately for use solely by the treating provider.	

Section Four: Purpose of Request

Personal Billing/Insurance Transfer of Care Continuation of Care Legal Disability Worker's Compensation
Other (specify): _____

Section Five: Format and Delivery of Information (Select one option) **WE DO NOT ACCEPT CDs or FLASH DRIVES**

Mail (paper) Fax MyChart/Patient portal** In-person pick up*** Email****

** File size may limit what is accessible in the portal. If so, they will be mailed to the address listed on this release.
*** Please allow 21 calendar days for processing. You will be notified when the records are ready to pick up.
**** We encrypt all email communications to safeguard your information. However, please be aware that this is the only measure we can provide to ensure the security of your medical records during transmission. Email remains inherently vulnerable to unauthorized access, and we recommend exercising caution when sharing sensitive information. File size my limit what we can send via email. If so, they will be mailed to the address listed on this release.

Section Six: Effective and Expiration Date(s) of Authorization

This authorization is effective immediately. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I fail to provide a date, event, or condition, this authorization will expire in ninety (90) days from the date of signature.

Section Seven: Patient Considerations and Authorization

I understand that:

- I am not required to sign this authorization to receive medical treatment. Refusing to sign will not prevent or affect the care I receive from Avance Care, nor will it prevent Avance Care from seeking payment for services provided.
- I can cancel or revoke this authorization at any time by submitting a written request to the address provided at the top of this form, ATTN: Medical Records. Any revocation will apply only to information not yet released by Avance Care at the time it processes the revocation.
- If the individual or facility receiving this information is not a healthcare provider or medical insurance provider covered by privacy regulations, the information above may be subject to redisclosure. However, records related to substance use disorder treatment that are protected under Federal Confidentiality Rules (42 CFR Part 2) cannot be re-disclosed without my written authorization, unless otherwise permitted by those regulations (except for uses and disclosures for civil, criminal, administrative, or legislative procedures against you).
- I have a right to receive a copy of this form upon request.
- A fee may be charged for providing the requested protected health information. Please visit our website <http://www.avancecare.com/medical-records> for a list of fees.

I acknowledge that I have read and understand the terms of this authorization and voluntarily provide my consent for the release of my medical records as indicated above.

SIGNATURE OF PERSON GIVING CONSENT OR LEGAL REPRESENTATIVE DATE

PRINT NAME OF PERSON GIVING CONSENT RELATIONSHIP TO INDIVIDUAL (Self*, Parent, Guardian, or Authorized Representative)

A patient (18 years or older) must authorize the release of their own information unless the patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require the minor’s authorization.



CONSENT TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS, FRIENDS, OR OTHERS

You have the right to identify family, friends, or others involved in your care to verbally receive medical or payment information about you, to help you manage your health care. You may make changes to this list at any time by submitting

a new form. Avance Care will only share your health information with the individuals you designate, except as required by law. This consent form does NOT authorize releasing copies of your patient health records, which requires an **Authorization for Release of Medical Records Form**.

I decline the verbal disclosure of my health information to any parties. I understand that this declination can be revoked at any time by completing and submitting a new form.

I, the undersigned patient or patient’s legal representative, consent for Avance Care to verbally disclose the information I have specified below with the following family, friends, or other individuals (as specified below) pursuant to a request from the undersigned patient or legal representative:

Name	Relationship	Phone Number

1.Type of information to be verbally disclosed: (Check all boxes that apply)

ALL information (including billing information, information related to behavioral or mental health services including psychiatric consults, development disabilities, HIV/AIDS and test results, sexually transmitted diseases, hepatitis, tuberculosis, and social service needs), *excluding substance use disorder information*, as protected under 42 CFR Part 2.

Health Plan information ONLY (billing, benefits, payments authorizations) including updating demographic and other information

Other (describe): _____

However, I specifically withhold disclosure of the following types of information (patient to fill in examples of information to be withheld from the designated individuals)

I understand that this authorization is voluntary and that I have the right to revoke it at any time, except where the organization has already made disclosures based on this consent. This authorization will remain in effect for two years from the date of signing and will need to be renewed thereafter. If a new Consent to Verbally Disclose Protected Information to Family Members, Friends, or Others form is received with updated permissions for the same family member, friend, or other person, the new version will automatically revoke the previous one on file. If this consent is signed by a minor, it will automatically expire when the minor reaches the age of 18 years old.

Signature of Patient/Authorized Individual

Date

Patient Name

Date of Birth

If signed by a personal representative of the patient, please print name below and indicate relationship to the patient. For Legal Guardian or Power of Attorney, please submit Legal Documentation with this form.

Print Authorized Representative Name

Relationship to Patient