

<b>Section A: This section must be completed for all Authorizations</b>			
<b>Patient Name:</b>	<b>Date of Birth:</b>	<b>Patient's Phone:</b>	<b>Last 4 digit SSN (optional)</b>
<b>CarePartners Service Line:</b> <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Outpatient Rehab <input type="checkbox"/> Home Health <input type="checkbox"/> PACE <input type="checkbox"/> Hospice <input type="checkbox"/> Palliative Care <input type="checkbox"/> Private Duty <input type="checkbox"/> Other _____			
CarePartners Provider Address:			
<b>Recipient/Facility Name</b>		<b>Recipient's Phone:</b>	
<b>Address 1:</b>		<b>Recipient's Fax Number:</b>	
<b>Address 2:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Request Delivery (If left blank, a paper copy will be provided):</b> <input type="checkbox"/> Paper Copy <input type="checkbox"/> Electronic Media, if available (e.g., CD/DVD) <input type="checkbox"/> US Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Unencrypted Email <b>NOTE:</b> In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.			
<b>Email Address (If email checked above. Please print legibly):</b> This authorization will expire on the following: (Fill in the Date or the Event but not both.) <b>Date:</b> _____ <b>Event:</b> _____			
<b>Purpose of disclosure:</b>			
<b>Description of information to be used or disclosed</b>			
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.			
<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>
<input type="checkbox"/> All PHI in medical record	_____	<input type="checkbox"/> Assessments/Evaluations	_____
<input type="checkbox"/> Admission form	_____	<input type="checkbox"/> Treatment Plans	_____
<input type="checkbox"/> Discharge Summary	_____	<input type="checkbox"/> (POT/Certification/Care Plan)	_____
<input type="checkbox"/> History and Physical	_____	<input type="checkbox"/> Treatment/Visit Notes	_____
<input type="checkbox"/> Medical Progress/Visit Notes	_____	<input type="checkbox"/> Therapy/Clinical Summaries	_____
<input type="checkbox"/> Lab Reports	_____	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Radiology Reports	_____	<input type="checkbox"/> Itemized bill: _____	_____
		<input type="checkbox"/> UB-04: _____	_____
		<input type="checkbox"/> Other: _____	_____
		<input type="checkbox"/> Other: _____	_____
		<input type="checkbox"/> Other: _____	_____
		<input type="checkbox"/> Other: _____	_____
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)			
I understand that:			
1. I may refuse to sign this authorization and that it is strictly voluntary.			
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.			
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.			
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.			
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.			
6. I get a copy of this form after I sign it.			
<b>Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.			
Will the recipient receive financial remuneration in exchange for using or disclosing this information?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:			
May the recipient of the PHI further exchange the information for financial remuneration?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Section C: Signatures</b>			
I have read the above and authorize the disclosure of the protected health information as stated.			
<b>Signature of Patient/Patient's Legal Representative:</b>		<b>Date:</b>	
<b>Print Name of Patient's Legal Representative:</b>		<b>Relationship to Patient:</b>	

DO NOT WRITE IN MARGIN

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**Authorization for Access, Use,  
or Disclosure of Protected  
Health Information**

