CenterWell ACE

Authorization for Release and Disclosure of Protected Health Information TO CenterWell

PATIENT NAME		
ADDRESS	CITY	ZIP
DATE OF BIRTH	EMAIL	
HOME PHONE #	CELL PHONE #	

I authorize the following to release & disclose my protected health information ("**PHI**") to CenterWell ACE entities, including CenterWell Senior Primary Care and Conviva Care Centers (collectively "**CenterWell**"):

Check one box only

☐ Class of Healthcare Providers: Any physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other healthcare provider that has provided (or is currently providing) payment, treatment, or services to me or on my behalf.

OR

☐ Specific Provider or Healthcare Entity:

Name: _____

Phone #: _____ Fax #: _____

Address: _____

City: _____ State: _____ Zip: _____

Type of provider/entity: _____ (specialist, hospital, clinic, lab, etc.)

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"), which includes PHI collected and maintained by the Disclosing Provider/Entity, 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 (to/from 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 (to/from other providers or treatment centers) ☐ Imaging (x-rays, EKG, etc.)
☐ Other (describe): _____

(Optional) Specific Treatment Dates*. I authorize disclosure of PHI from only the following treatment dates:

From (date) _____ To (date) _____

**Selecting specific treatment dates will not impact this authorization's Expiration Date/Event.*

PURPOSE OF AUTHORIZATION: To release information at the request of the individual authorizing disclosure. If this authorization is for a different purpose, please specify:

_____

EXPIRATION: This authorization is valid until the earlier of the occurrence of the patient's death, or **36 months** from the date of signature. **Optional:** you may specify a period of less than 36 months here: _____ month(s).

I UNDERSTAND THAT:

- I can withdraw my permission at any time by giving written notice to the Disclosing Provider/Entity, 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.

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.):

_____