CONVIVA Care Center

Authorization for Release Request to Provider

I hereby give my permission to this provider organization to release or to request personal health information contained in my medical records to the organization listed.

Patient Name: _____ _____ _____
Last Name MI First Name

Mailing Address: _____ Bldg. No. _____ Apt. No _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Medical Record # _____

Please print/type all requested information.

Provider requesting PHI name & address:

Provider / Facility: _____
Facility Address: _____
City: _____ **State:** _____ **Zip:** _____
Fax #: _____ **Phone #:** _____

Provider responding to PHI request:

Provider / Facility: _____
Facility Address: _____
City: _____ **State:** _____ **Zip:** _____
Fax #: _____ **Phone #:** _____

I understand that this authorization will allow this provider organization and its affiliates to use or disclose my protected health information. **I understand that my medical record may contain sensitive information such as mental health, HIV, AIDS, substance use disorders, sexual abuse and /or other related conditions.** I understand that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an express and informed written consent. In addition, I understand that these records will not be released to entities other than those designated by myself or my personal representative as provided by state or federal law.

Disclaimer: *The doctors, nurse practitioners, and physician assistants providing healthcare services to you today are employees of Conviva Physician Group. They are independent contractors and are not employees or agents of Conviva Care Solutions or your practice*

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Patient Name: _____ _____ _____

Last Name MI First Name DOB

Please select only one option below:

☐ **I authorize release or request of all of my medical records including sensitive information (such as mental health, HIV, health status, or substance use disorders).**

☐ **I authorize release or request of information only for treatment dates of:**

_____

☐ **I authorize only the following items of information to be disclosed or released:**

Please place a check mark beside those items that you allow to be disclosed.

☐ **Discharge Summary**
☐ **Treatment Plans**
☐ **Labs**
☐ **Immunizations**
☐ **Psychological / psychiatric Evaluations**
☐ **Progress Reports/ Notes**
☐ **Social Development History**
☐ **X- Rays**
☐ **Special Studies (EKG, Mammogram, etc.)**
☐ **All of my medical records including sensitive information (such as mental health, HIV, health status, sexual abuse or substance abuse records)**
☐ **other (describe)**

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Last Name MI First Name

**** I understand that records sent through unencrypted email pose a security risk but it is my requested method.**

I understand the following:

- I may revoke this authorization at any time by providing written revocation to this facility.
- I understand that a revocation of this authorization will not apply to any actions taken or information released prior to my written revocation.
- I understand that authorizing the disclosure of this information is voluntary. I also understand that treatment, payment or eligibility for services is not based upon signature of this authorization.
- I understand that information used or disclosed prior to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal privacy laws.
- I understand that this provider organization will release only the minimum amount of information necessary to fulfill the request.
- I understand that this authorization is valid for one (1) calendar year from date of signature unless I send a written request to the facility to revoke this request.
- I understand that information released will be to provide continuity of care and could include sensitive information (such as mental health, HIV, health status, sexual abuse or substance use disorders).

_____ | |
Patient Name | Signature and Date

_____ | |
Name of Witness or legal representative | Signature and Date

FOR INTERNAL USE ONLY
Complete the sections below and place in patient record.

_____
Name of associate who processed request **Date**

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Last Name MI First Name

Discrimination is Against the Law

Conviva Care Solutions and its subsidiaries ("Conviva") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Conviva Care Solutions and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Conviva Care Solutions and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-2188 or if you use a TTY, call 711.
If you believe that Conviva Care Solutions and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights / LEP/ ADA/ Section 1557 Compliance Officer 500
W. Main – 10th Floor
Louisville, Kentucky 40202

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room
509F, HHH Building Washington, D.C.
20201

1-800–368–1019, 800-537-7697 (TDD)

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Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-320-2188 (TTY: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-320-2188 (TTY: 711)**.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-320-2188（TTY:711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-320-2188 (TTY: 711)**.

한국어 **(Korean):** 주의: 한국어를사용하시는경우, 언어지원서비스를무료로이용하실수있습니다. **1-877-320-2188 (TTY: 711)** 번으로 전화해 주십시오 .

Tagalog (Tagalog --- Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-320-2188 (TTY: 711)**.

Русский(Russian): ВНИМАНИЕ: Если вы говорите на русском я зыке, то вам доступны бесплатные услуги перевода. Звоните **1-877-320-2188 (телетайп: 711)**.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-320-2188 (TTY: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-320-2188 (ATS : 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-320-2188 (TTY: 711)**.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-877-320-2188 (TTY: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-320-2188 (TTY: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-320-2188 (TTY: 711)**.

日本語 **(Japanese):** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-320-2188**（**TTY**：**711**）まで、お電話にてご連絡ください。

فارسی (Farsi): هجوت:دشابیممهارفامشیاربناگیارتروصبینابزتلایهست،دینکیموگتفگیسرافنابزهبرگا.اب تسامبیگرید. **(TTY:711)1-877-320-2188**

DinéBizaad(Navajo):D77baaak0n7n7zin:D77saadbeey1n7[ti'goDinéBizaad,saadbee 1k1'1n7da'1wo'd66', t'11jiik'eh,47n1h0l=, koj8' h0d77lnih**1-877-320-2188 (TTY: 711)**.

العربية (Arabic): 1-877-320-2188 ةظوحلم:ركذاثدحتتتنكاذإ نإف،ةغلا ةدعلسماتامدخ رفاوتتقيوغلا نجملابكل. مقربلصتا **711 (. :مصلافتاه مكبلاو مقر**

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