CenterWell ACE

Patient Request for Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Patient Email: _____
Home Phone #: _____ Cell Phone #: _____

This form may be used by patients or their personal representatives to request the patient's PHI FROM CenterWell ACE entities, including CenterWell Senior Primary Care, Conviva Care Center, and Elite Health Medical Centers (collectively, "**CenterWell**"), or an associated Behavioral Health Provider. Paper or email copies of the PHI may be provided TO the patient/personal representative, or email copies (only) of the PHI may be sent to another person or entity designated by the patient/personal representative.

REQUEST PHI FROM:

_____
Name of CenterWell ACE entity (CenterWell/Conviva/Elite) and Name of Facility

OR

_____
Name of Behavioral Health Provider and their associated CenterWell ACE entity (CenterWell/Conviva/Elite)

HEALTH INFORMATION TO BE RELEASED – *Please read carefully*

I understand that I am requesting that my PHI—which includes PHI collected and maintained by CenterWell ACE or an associated behavioral health provider, information on health treatment programs, plan information, and caregiver resources—be released to myself, my personal representative, or to another person or entity. 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 the PHI that you want released. If all information is to be released, then only check the appropriate box on Line 1.

☐ **Complete Release** of Primary Care Record Set **OR** ☐ Behavioral Health Record Set
☐ **Limited Release** of Primary Care Record Set **OR** ☐ Behavioral Health Record Set

☐ Progress Notes ☐ Treatment Plans ☐ Immunizations/Vaccines
☐ Insurance/Claims Data ☐ Diagnostic Test Results/Reports ☐ Pharmacy/Prescriptions
☐ Outside Records/Referrals ☐ Other (describe): _____

Date range: FROM _____ (mm/dd/yyyy) TO _____ (mm/dd/yyyy)

DELIVERY PREFERENCE:
Select one

☐ Mail paper copy to patient or personal representative at:

_____

☐ Call: _____ for patient or personal representative to pick-up paper copy
Pick-up from: _____ (facility)

☐ Email to patient or personal representative at: _____

☐ Email to person or entity (other than the patient or their personal representative):
Name: _____ Phone #: _____
Email: _____
Relationship: _____ (spouse, friend, attorney, doctor, etc.)

Signature of Patient or Patient's Legally Authorized Personal Representative* **Date**

Printed Name of Legally Authorized Personal 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.): _____