Authorization to Disclose, Use and Release Protected Health Information

Please use this form to request a copy of your medical records, authorize use or have us send your records to a designated person or entity. Print clearly and legibly when completing this form. ***Required information**

Patient Information*

Last Name:*	Legal First Name:*	M.I.:
Address:*	Apt#:	Phone#:
City:*	State:*	Zip:*	Date of Birth (mm/dd/yyyy):*

Step 1: Tell us what you would like to do.

☐ Obtain a Copy of My Health Records (Skip steps 2 &3) ☐ Send My Everside Health Records to another person/entity ☐ Obtain a copy of my Health Records from another provider and send to Everside Health

Step 2: My Health Information may be shared with the following by Everside Health:*

Name of Person/Entity:*

Address:*

City, State, Zip:*

Phone: Fax:

Step 3: My Everside Health Office Location:

Have you been seen at more than one Everside Health location? Yes / No

Everside Health Office:

Address:*

City, State, Zip:*

Phone: Fax:

Purpose of Request: (Please check one)

☐ Individual's request ☐ Legal ☐ Insurance ☐ Other: _____

Health Information:* (Please check one)

☐ All records retained by provider for ☐ all dates of service or ☐ from _____ to _____

☐ The types of records indicated below between the following dates of service: from _____ to _____

☐ Progress notes ☐ Laboratory reports ☐ Immunization records ☐ Hospital records ☐ Imaging reports

☐ Other Specified Information: _____

Disclosure of Sensitive Information

I understand that my health record may contain sensitive and protected information relating to my medical condition(s) and treatment. This includes, but is not limited to, information relating to HIV or confirmed diagnosis of or treatment for any other sexually transmitted disease, behavioral or mental health services and treatment for alcohol and drug abuse ("Sensitive Information").

☐ By checking this box, I choose to exclude/not disclose the above types of Sensitive Information from this disclosure.

☐ Other information I desire to exclude from this disclosure: _____

Terms and Conditions

- I have the right to revoke this Authorization, in writing, at any time by notifying the Privacy Officer at Everside Health and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that has already been disclosed. To contact the Privacy Officer, please call 1-866-808-6005, option 3 or email compliance@eversidehealth.com.
- I may refuse to sign this Authorization. My refusal will not impact my ability to obtain treatment or payment or eligibility for benefits.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization, have had an opportunity to have my questions answered, receive a copy of this Authorization, and have signed this Authorization freely.
- I may be responsible for the cost of copying my medical records under state law.
- This Authorization expires one (1) year after the date of signature unless otherwise specified. Expiration Date _____

Signature of Patient or Legal Representative/Guardian* Signed Date*

Print Patient's Name Print Legal Representative/Guardian's Name (if applicable) Relationship to Patient

Patient's Personal Representative: If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the patient named above and I am not prohibited by Court Order from authorizing disclosure of the requested information.

PLEASE RETURN THIS FORM TO: memberservices@EversideHealth.com