Authorization to Release Protected Health Information

Request a copy of your medical records or send your records to Everside Health or another doctor.
Please print clearly and legibly when completing this form.

Patient Information

Last Name:*	Legal First Name:*	M.I.:
Address:*		Apt#:

City:*	State:*	Zip:*	Date of Birth (mm/dd/yyyy):*

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

☐ Obtain a Copy of My Everside Health Records (Skip steps 2 & 3)

☐ Send My Everside Health Records to another doctor

☐ Obtain a copy of my Health Records from another doctor and send to Everside Health

Step 2: Provide contact information for the non-Everside Health healthcare doctor.

Name of Physician/Provider:

Address:*

City, State, Zip:*

Phone: Fax:

Step 3: Verify your Everside Health doctor information.

Everside Health Location:

Address:*

City, State, Zip:*

Phone: Fax:

Purpose of Disclosure: (Please check one)

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

Purpose of Disclosure: (Please check one)

☐ All records retained by doctor

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

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

☐ Colonoscopy/Cologuard ☐ PAP/HPV ☐ Mammogram

☐ Other specified information: _____

Disclosure of Sensitive Information

I understand that my health record may contain sensitive information relating to my condition(s). 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.

☐ By checking this box, I choose to exclude the above types of information 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 email privacy@eversidehealth.com.
- I may refuse to sign this Authorization. My refusal will not effect 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, have signed this Authorization freely and have received a copy of this Authorization.
- 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: _____

Signature of Patient or Legal Guardian

Signed Date

Print Patient's Name

Print Legal Guardian's Name (if applicable)

Relationship to Patient

**Required information*