Authorization to Release Protected Health Information

Request a copy of your medical records or send your records to Everside Health or another provider/individual or entity. Fax completed forms to Medical Records at (888) 734-5397 or email to medicalrecords@eversidehealth.com.

everside HEALTH

Patient Information

Last Name:*	Legal First Name:*	M.I.:
Date of Birth (mm/dd/yyyy):*	Today's Date (mm/dd/yyyy):*	
Address:*		Ste#/Apt#:
City:*	State:*	Zip:*
Email:*	Phone:*	
Parent/Guardian Name (if applicable):	Relationship to Patient (if applicable):	

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

☐ Obtain a Copy of My Everside Health Records (Complete Steps 2 & 4)

☐ Send My Everside Health Records to another Provider/Individual/Entity

☐ Obtain a Copy of My Health Records from another Provider and send to Everside Health

Step 2: How do you want the records sent?

☐ Send Via Encrypted File to Email (Preferred) ☐ Mail to Address ☐ Fax To: _____

Step 3: Provide contact information for the non-Everside Health Provider/Individual/Entity.

Provider/Individual/Entity:*	
Address:*	
City, State, Zip:*	
Phone:*	Fax:
Email:*	

Step 4: Verify your Everside Health Provider information.

Everside Health Location:*	
Address:*	
City, State, Zip:*	
Phone:*	Fax:

Purpose of Disclosure: (Please check one)

☐ Patient's Request ☐ Legal ☐ Insurance ☐ Employer ☐ Continuity of Care ☐ Other: _____

Information to Disclose: (Please check one)

☐ All records retained by physician/provider (Clinical Health Records **may include Occupational Health Records**.)

☐ 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 ☐ Bone Density/DEXA ☐ Eye Exam ☐ Low Dose CT Chest ☐ Aorta U/S

☐ 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 (when provided by specialists in that field), and treatment for alcohol and drug abuse (when provided by specialists in that field).

I would like to **include the following:**

☐ HIV ☐ Sexually Transmitted Diseases ☐ Behavioral or Mental Health Services ☐ Treatment for Alcohol and Drug Abuse

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 affect 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 Parent/Legal Guardian _____ Date _____

Required information