true health
REAL CHOICES. REAL CARE.

Authorization to Obtain Health Information

Patient Name:_____ Date of Birth: _____

Requesting Release From: (Doctor's Office/Name): _____

Address: _____ Phone:_____ Fax:_____

I authorize **True Health** to use or disclose the above-named individual's health information as described below. This information is being requested for the patient's continued care. The type and amount of information to be usedor disclosed is as follows: (include dates where appropriate)

- ☐ Problems, Medications, and Allergies
- ☐ Most recent History and Physical
- ☐ Operative Reports
- ☐ Most recent Discharge Summary
- ☐ Laboratory and Imaging Reports
- ☐ Consultation reports
- ☐ Entire Health Record

Details: _____
Dates: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to (person) , Privacy Officer.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact P(erson), Privacy Officer.

I_____, state and attest that I may legally access medical, mental health and/orsubstance abuse treatment records for the above-named patient, a minor child.

_____ _____

Signature of Patient or Legal Representative Date