AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Must be completed in order to release information

I hereby authorize the use and disclosure of information from the medical record of:

Patient Name: *Last:_______________ *First________________ MI: ____ Maiden Name:____________

*Date of Birth: ____________________________ Social Security Number: XXX-XX-__________________

I authorize TotalCare to disclose the above name individual's private health information.
This information may be disclosed TO and used by the following individual or organization:

*Facility Name: ____

*Address: ____

*City/State/ZIP: ____

*Phone: __________________________________ *Fax ____________________________________

For the purpose of:
____

*Please release the following:

___ Entire Record ___ Billing Records: from (date) __________ to (date) __________

___ Other (specify): ____

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

___ **Yes,** I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

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 the individual or organization releasing information. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: ______________________________

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in the CFR 164.524. 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 of my health information, I can contact the TotalCare Medical Records Department.

____________________________________ ____________________________________
Signature of Patient or Legal Representative Date

____________________________________ ____________________________________
Relationship to Patient (If Legal Representative) Witness

PLEASE COMPLETE PAGE TWO OF THIS FORM IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT / PATIENT REPRESENTATIVE.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of information contained in these entries. I will not hold TotalCare liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

______________________________	______________________________
Signature of Patient or Legal Representative	Date
______________________________	______________________________
Relationship to Patient (If Legal Representative)	Witness

Cost of Paper Copies:
$14 (pages 1-25)
$4 each additional 10 pages
Postage costs if applicable

Cost of Electronic Copies:
$15 (up to 500 pages)
$30 (over 500 pages)
Postage costs if applicable

Cost of Affidavits/Notary (If needed):
$15 per signed page

I request that TotalCare provide me with a copy of my protected health information in the following form or format:

___ Paper ___ Flash Drive ___ Fax - Fax Number: ______________________________

___ Email - Email Address: ____

www.totalcare.us