SimpleTherapy® | SimpleMSK

AUTHORIZATION TO RELEASE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. Refusal to sign this authorization will not affect patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill patient's insurance company.

Patient's Name: _____ Date of Birth: _____

Nickname/Maiden Name: _____ Telephone: _____

Address: _____

I request and authorize, SimpleMSK to release healthcare information to the person listed below:

Name: _____

Address: _____

Telephone: _____ Relation to Patient: _____

The purpose of this release: _____

If such information exists, I authorize the disclosure of ☐ the entire medical record or ☐ the following specific documents, dates of service, and/or information about the following injury/illness/disease:

☐ Referral Information ☐ Name & Contact Information of Treatment Provider(s)

☐ Treatment Information ☐ Claim Information & History ☐ Other: _____

The following items must be initialed to be released:

_____ HIV-positive test results and HIV diagnosis

_____ Mental health information and/or records

_____ Genetic testing information and/or records

_____ Other sexually transmitted diseases

_____ Drug/alcohol diagnosis, treatment or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed: _____

Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire on the earlier of one (1) year from the date of signing or on _____.

Signature of Patient or Patient's Legal Representative: _____ Date Signed: _____

Print Name (If other than patient, proof of authority is required): _____ Relationship to Patient: _____