neighborcare health

Authorization To Release Patient Health Information

This form may also be used for a patient to authorize the use or disclosure of their health information to Neighborcare Health from another organization.

Patient Name: _____ Date of Birth : _____/_____/_____

Previous Name (if applicable)_____

Reasons(s) for this authorization (Check all that apply):

☐ **I wish to receive my records electronically on a disc/CD**

☐ Personal Use ☐ Transfer to another provider ☐ Legal Use ☐ Continuing Care ☐ Other (specify):_____

Information to be Released FROM:	**Information to be Released TO:**
☐ **Neighborcare Health or**	☐ **Neighborcare Health or**
_____ Organization or Company	_____ Organization or Company
_____ Address City, State, Zip	_____ Address City, State, Zip
_____ Phone Fax	_____ Phone Fax

Information to be Disclosed/Released

Neighborcare Health may use or disclose the following healthcare information (check all that apply):

☐ Entire Completed Chart Record

☐ OB Reports: ☐ All ☐ Specify:_____

☐ Labs/Reports: ☐ All ☐ Specify:_____

☐ Immunization/Shot Records

All Other Medical History (Please Specify):_____

This authorization will expire one year from the date signed below unless another date or an event is entered here:_____

Releasing Sensitive Information-IMPORTANT

I authorize the release of the following sensitive information. Please check the applicable boxes below to request the following records:

☐ HIV (AIDS virus) ☐ Sexually Transmitted Diseases ☐ Mental Health ☐ Drug and/or alcohol use

My Rights as a Neighborcare Health Patient

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

* To take part in a research study or
* To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Neighborcare Health or the organization indicated above where my information is being released to.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature of Patient/Legally Authorized

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)