advocare

Authorization for Use/Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Information (Please Print):

Patient Name: _____ Date of birth: _____

Address: _____
(Street Address) (City) (State) (ZIP)

Phone Number: _____

I authorize (Sending Provider):

_____
Provider/Facility Name

_____
Street Address

_____
City, State, ZIP

_____
Phone Number

To release to (Recipient):

_____
Recipient of records

_____
Street Address

_____
City, State, ZIP

_____
Phone Number

_____
Email

Send via mail or
Email

Purpose for the record request:

Continued Care Transfer of Care Patient Request Other (please specify): _____

Covering the period(s) of health care: From: _____ To: _____

Select from the following the information to be disclosed (check all that apply):

Abstract Record (Last year of encounters and procedures, lab results, and diagnostic results)
Complete Medical Record (All records available for the dates requested above)
Immunization Record
Growth Charts
Encounters
Lab Reports
Diagnostic Imaging Reports
Photographs, videotapes, digital or other images
Operative/Procedure Reports
Consultation Reports
Cardiology/EKG Report
Itemized Billing Statements
Other (please specify): _____

I authorize the following information to be included (See **reference guide** bottom of Page 2) Please select:

Mental health care or services
Treatment for alcohol and/or drug abuse
AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
Reproductive Services

By signing this form, the Patient or Patient's Legal Representative attests to reading and accepting the following statements:

1. I understand that unless earlier revoked, this authorization expires on ____/____ /20___ or on the happening of _____ .
   (If no expiration date is designated, this authorization will expire in 90 days from the signature date.)
2. I understand that I may revoke this Authorization at any time by notifying Advocare, LLC, in writing, but if I do so my revocation will not have any effect on any actions Advocare, LLC, took in reliance on this Authorization before it received my revocation.
3. I understand that Advocare, LLC, cannot make me sign this Authorization as a condition to receive treatment from Advocare, LLC:
   i. When Advocare, LLC, provides me with research related treatment; or
   ii. When Advocare, LLC, provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
4. I understand and accept that by law you have 30 days to comply with my request.

Advocare, LLC, its providers, employees, members, and agents are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
(Form MUST be completed before signing)

Signature of Patient or Legal Representative: _____

Print Name: _____ Dated: _____

If Signed by Legal Representative, state relationship to patient: _____

Note: If you are the Patient's Legal Guardian other than a parent, or if you are the Patient's Power of Attorney, a copy of the legal document granting you such power must be attached to this request.

Reference Guide	
Mental healthcare or services	Psychiatric or psychological information, including any psychiatric or psychological treatment given by my provider.
Treatment for alcohol and/or drug abuse	Drug or alcohol information, including any drug or alcohol treatment or tests ordered by my provider.
AIDS or HIV infection	AIDS or HIV related information, including any AIDS or HIV-related treatment or tests ordered or by my provider.
Reproductive Services	All medical, surgical, counseling, or referral services relating to the human reproductive system including, but not limited to, services relating to pregnancy, contraception, or termination of a pregnancy. (Reproductive Law P.L.2022, c.51)