advocare

Authorization for Use/Disclosure of Protected Health Information

I hereby authorize the Sending Provider identified below to use or disclose the Patient's protected health information as described below. ***Note: You must complete this entire form for it to be valid.***

Patient Information (Please Print):

Patient Name: _____ Date of birth: _____

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

Phone Number: _____

I authorize the below ("Sending Provider"):

☐ Advocare, LLC ***OR***

☐ Other Provider/ Facility (complete information below):

Name of Provider/Facility

Street Address

City, State, ZIP

Phone Number

To release to the following entity/person ("Recipient"):

Name of Recipient of records

Street Address

City, State, ZIP

Phone Number

Email (if records may be emailed)

Send via: ☐ Email or ☐ Mail

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, to the extent it is present in the Patient's records.

(See reference guide; bottom of Page 2) Please select all that apply:

☐ Mental health care or services
☐ Treatment for substance use disorder
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
☐ Reproductive health care services

Reason for the request:

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

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

By signing this Authorization, the Patient or Patient's Legal Representative understands that:

1. If the Recipient authorized to receive the Patient's information is not a health plan, health care provider, or an entity with which they contract (called a "business associate"), the released information may no longer be protected by federal and state privacy regulations and laws.

2. Unless earlier revoked, this Authorization expires on ____ /____ /20 ___ or on the happening of

   _____.

   (If no expiration date is designated, this Authorization will expire 90 days after the signature date.)

3. This Authorization may be revoked by me at any time by notifying the Sending Provider in writing, except to the extent that information has already been disclosed/used. If information has already been disclosed/used in reliance on this Authorization, revoking it will only prevent further disclosure/use.

4. This Authorization is voluntary, and a provider cannot make me sign it as a condition to the Patient receiving health care services unless this Authorization directly relates to:
   i. Research-related treatment the Patient is receiving; or
   ii. Health care services the Patient is receiving solely for the purpose of creating protected health information for disclosure to someone else.

To the extent I am authorizing Advocare to release information to a third party, I hereby release Advocare, its providers, employees, members, and agents from any legal responsibility or liability for disclosure of the information to the extent indicated and authorized herein.

Signature of Patient or Legal Representative: _____

Print Name: _____ Dated: _____

If signed by a Legal Representative*, state relationship to patient: _____

Note: Unless the Patient is a minor and you are the Patient's parent, all Legal Representatives must attach a copy of the legal document showing that you have the authority to sign this Authorization.

Reference Guide	
Mental health care or services	Psychiatric or psychological information, including any psychiatric or psychological treatment given by my provider.
Treatment for substance use disorder	Substance (drug or alcohol) use disorder ("SUD") history/ information, including any SUD treatment or tests ordered by my provider
AIDS or HIV information	AIDS or HIV related information, including any AIDS or HIV-related treatment or tests ordered or by my provider.
Reproductive health care 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. (N.J.S.A. 2A:84A-22.18)