WellAway

Authorization for Use or Disclosure of Protected Health Information

SECTION A. AUTHORIZATION

I, _____, authorize the use and/or disclosure of health information from my medical record.
(Name of Patient)

Date of Birth:_____ **Policy ID:**_____

SECTION B.

Information to be disclosed by:	**Information to be provided/sent to:**
Name and Address of Facility/Provider	Name and Address of Person/Organization/Facility
Email Address	Email Address
Telephone/Fax Number	Telephone/Fax Number

SECTION C. PURPOSE OR NEED FOR DISCLOSURE IS:

☐ Continued Treatment ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other _____

SECTION D. INFORMATION TO BE DISCLOSED FROM MY MEDICAL RECORD *(Check appropriate box(es) below)*:

☐ Only information related to (specify) _____

_____

☐ Only for dates of service from _____ to _____

☐ Other (specify) (ex: radiology, billing, etc.) _____

☐ Entire Record

SECTION E. IF YOU WOULD LIKE ANY OF THE FOLLOWING SENSITIVE INFORMATION DISCLOSED, CHECK THE APPLICABLE BOX(ES) BELOW:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Sexually Transmitted Diseases ☐ Genetic Testing
☐ HIV/AIDS Testing & Treatment ☐ Sexual & Reproductive Health

SECTION F. REVOCATION

I may revoke this authorization by notifying the Facility/Provider in writing of my desire to revoke it. However, I understand that any actions already taken based on this authorization cannot be reversed and my revocation will not affect those actions.

SECTION G. EXPIRATION *(when this authorization will end)*

☐ This authorization will expire one year from the date on which it was signed.
☐ This authorization will expire on the following date or event specified: **Date** *(mm/dd/yyyy)*: _____

SECTION H. APPROVAL

I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment of claims, enrollment or eligibility for benefits.

I also understand that if the person or organization that I authorize to receive the information described above is not subject to federal privacy laws, it may be re-disclosed by such person or organization and may no longer be protected by federal privacy laws. However, under federal and state laws, the recipient may be prohibited from re-disclosing substance abuse and HIV/AIDS information without a specific written consent of the person to whom it pertains, or as otherwise permitted by such laws.

Signature of Member/Personal Representative: By signing below, I authorize the release of my protected health information as described above.

Print Name:	**Signature:**	**Date** *(mm/dd/yyyy)*:
Relation to Member:		

The member is unable to consent because (select one):

☐ Minor ☐ Incompetent ☐ Other *(explain)* _____

You are entitled to a copy of this authorization after you sign it.