Traverse Health Clinic and Coalition
D.B.A. Traverse Health Clinic

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name:_____Today's Date_____

Patient Birth Date: _____ Patient Address:_____

I authorize the Organization/Provider/Person named below in item 2 to release health information regarding me (including if applicable, information about HIV infection or AIDS, information about substance use disorder treatment, information about sexually transmitted diseases, information about genetic testing, and information about social work or mental health services except for psychotherapy notes) under the following terms and conditions:

1. Detailed description of the information to be released:

2. Organization/Provider/Person authorized to release information [names or classes]:

3. To whom may the information be released [name(s) or class(es) of recipients]:

4. The purpose(s) for the release:

□ for health treatment.

□ for payment for health care services.

□ to obtain benefits, such as Social Security or public welfare benefits.

□ for legal matters.

□ other (please explain) _____

_____

5. Expiration date or event relating to the individual or purpose for the release:

Insert Date or Description of when this Release Ends -

It is completely your decision whether or not to sign this authorization form. Except for instances where your agreement is necessary for treatment, payment, or health care operations, the Organization/Provider/Person named in this authorization cannot refuse to treat you if you choose not to sign.

You have the right to revoke this authorization at any time, unless an Organization/Provider/Person has already released information in reliance upon having it. If you want to revoke, send a written or electronic note to the Privacy Officer of the Organization, the Provider or Person that you authorized to release information.

With the exception of substance use disorder treatment information, mental health information or HIV/AIDS information, the recipient of your disclosed information may have no legal duty to further protect the confidentiality of your health information. In some cases, the recipient may re-disclose the information as he/she wishes.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

Date:_____ Patient signature: _____

If you are signing as a parent or personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient:_____Print Name:_____

Source of Authority _____

(Attach relevant documents, if applicable, such as guardianship papers, power of attorney, etc)