AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: ____

Date of Birth: ____________________

I HEREBY AUTHORIZE AbsoluteCARE, Inc to disclose PHI concerning the above-named person to the following recipient:

SEND RECORDS TO:

____

(organization's or individual's name)

____

(complete address)

____

(fax number)

RECEIVE RECORDS FROM:

I HEREBY AUTHORIZE ____

Fax Number: ____

to disclose PHI concerning the above-named person to AbsoluteCARE, Inc. at 2140 Peachtree Road, Suite 232, Atlanta, GA 30309 or to fax number 404-231-5677. If you have questions or concerns, please call 404-231-4431.

CHECK TYPE OF INFORMATION AUTHORIZED TO BE DISCLOSED:

☐ Entire record including, if applicable information related to HIV/AIDS, sexually transmitted diseases, psychological/psychiatric counseling and treatment or substance abuse treatment

☐ Only the following specified records: ____

____

Treatment date(s): ____

For the following purpose(s): ____

This authorization shall remain in effect until __________ (date) or ______________ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below.

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol program. I understand that such information is subject to special protections under federal law. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization. _________ (initial here)

______________________________ ______________________________

Patient's Signature Date

If the person giving this authorization is acting as the patient's personal representative, complete the information below:

______________________________ ______________________________

Patient's Signature Date

RELATIONSHIP TO PATIENT (CHECK APPLICABLE BOX)

☐ I am the parent or legal guardian of the minor patient who lacks legal authority to consent to his/her own medical treatment.

☐ I have been given authority by a court of proper jurisdiction to act on the patient's behalf, including execution of this authorization.

☐ I have been formally appointed by the patient as his or her durable power of attorney and/or durable power of attorney for healthcare and the patient has an impairment that prevents him/her from making decisions on his/her own behalf.