AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Date _____ Patient's Name _____ D.O.B. _____

I hereby authorize:

alivation HEALTH

☐ To "Provide" Protected Health Information "To": ☐ To "Receive" Protected Health Information "From":

Name: _____ Title: _____

Address: _____

Phone #: _____ Fax #: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE RELEASED:

☐ Psychiatric Evaluation	☐ Progress Notes	☐ Psychological Evaluation
☐ Therapy Progress Notes	☐ List of Medications	☐ Substance Abuse Evaluation
☐ Verbal Communication	☐ Entire Record	☐ Other_____

I understand my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus, or other sexually transmitted diseases, or drug and alcohol abuse.

- EXPIRATION DATE: I understand that this authorization shall be in force and effect until _____ (state the specific expiration date or the event triggering the expiration) at which point the authorization will expire. If left blank, release will automatically set to expire one year from the date signed.
- REVOCATION OF AUTHORIZATION: I understand that I may revoke this authorization at any time by sending written notification to Alivation Health, 8550 Cuthills Circle, Lincoln, NE 68526. I understand that a revocation is not effective to the extent that the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- AUTHORIZATION FOR MARKETING: I understand that the authorized use or disclosure will result in a direct or indirect payment to the providing organization from a third party.(This section is necessary only if the authorization is for marketing purposes and involves direct or indirect payment to the covered entity from a third party.)
- CONDITIONING OF AUTHORIZATION: I understand that the providing organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on me providing an authorization for the requested use or disclosure. Unless my treatment is 1) related to the research, 2) my health care services are provided solely for the purpose of creating protected health information for disclosure to a third party, or 3) if the authorization is sought for a health plan to determine eligibility or enrollment for underwriting purposes.

Date: _____ **Signature of Patient or (Legal Guardian):** _____

Print name if signing as Legal Guardian: _____