8550 Cuthills Circe | Lincoln, NE 68526
Phone: 402.476.6060 | Fax: 402.476.6809
alivation.com

Release of Information

☐ **Behavioral Health** ☐ **Primary Care** **Patient Name**_____ **DOB**_____

I hereby authorize Alivation Health, LLC (*must check at least one)*:

☐ To "Provide" Protected Information "To":
(patient agrees that Alivation can *share* your health information *with:*)

☐ To "Receive" Protected Information "From"
(patient agrees that Alivation can *receive* your health information *from:*)

Name:_____ Phone:_____ Fax: _____

Address:_____ Email:_____

Purpose of Request (*must check at least one)*:

☐ Communicate to individual above* note: some items will not be released due to specialty ☐ Attorney / Legal

☐ Coordination of Care/Consultation ☐ Transferring Care ☐ Billing ☐ Other _____

I Request my records be provided (*must check at least one)*:

☐ Electronically via MyHealthRecord ☐ Paper (fees may apply) ☐ Electronically via email ☐ Electronically via CD*

Please check the type of information to be released (*check all that apply):*

☐ All previous dates ☐ From (date) _____ To (date) _____

☐ Consultations/Encounters	☐ PFT / Spirometry	☐ History / Physicals	☐ Orders	☐ Diagnostic Testing Reports
☐ Immunization Records	☐ Lab Test Results	☐ Questionnaires	☐ Meds	☐ EKG/Cardiology/Reports
☐ Sleep Study Reports	☐ Radiology/Images	☐ Pathology Reports	☐ Other: _____	

Drug and/or Alcohol Abuse, and/or Psychiatric and Communicable-Non-communicable Diseases:
I understand my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases (such as hepatitis, gonorrhea), psychiatric care, drug and alcohol abuse/treatment, or other sensitive information. I agree to its release. *Check One:* ☐ *Yes* ☐ *No*

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 on 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 overage 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 request use or disclosure. Unless my treatment is 1) related to the research, 2) my health care services are provided solely for 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.

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

Print Name if signing as Legal Guardian: _____

Office Use Only

Alivation Health Witness Name: _____ Date: _____

Action Needed (leave blank if none):_____