ELEVATE HEALTHCARE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client's Full Name: _____ Date of Birth: _____ MRN#_____

*I authorize and request the following individual/organization: **Elevate Healthcare** to obtain and/or release information to/from:

_____ _____
Name of Organization Phone Number

_____ _____
Address Fax Number

_____
Purpose

Information to be released: Treatment Dates: _____

___Client Demographics
___Nursing Assessment
___Discharge Summary
___Psychiatric Evaluation
___Physician Orders
___Physician Notes
___Nursing Notes
___Therapy Notes
___Intake Assessment
___Master Treatment Plan
___Other: _____(specify)

*I understand that the information in my health records may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services and treatment for alcohol and drug abuse.

*I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department (HIM). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 180 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CRF 164.24. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact thePurpose Healthcare Health Information Management Department.

_____ _____
Client/Parent/Guardian Signature Date