CIFC Health

Authorization to Release or Obtain Health Information

Patient/Client Name:_____ DOB:_____

Home Phone:_____ Mobile:_____

Address:_____ Email: _____

I authorize **CIFC Health** to: ☐ **RELEASE** AND/OR ☐ **OBTAIN** the information below to or from:

Name:_____ Address:_____

Phone:_____ Fax:_____ Email:_____

Method of Delivery: ☐ Mail ☐ Fax ☐ Pick-up by: _____

Information to be released or obtained:

☐ Entire Record ☐ Consultation Notes ☐ Messages (TE)

☐ Progress/Session notes ☐ Billing Records ☐ Other: _____

For the following dates of service:_____

Check below if any (or all) of the below listed categories of **sensitive information** are to be included:

☐ Psychiatric/Behavioral Health ☐ Drug/Alcohol Abuse* ☐ HIV/AIDS Related Information

☐ Reproductive Health

*If you do not wish to disclose all your drug/alcohol abuse information, please indicate what information to exclude:

_____

I am requesting the release of the information above for the following purpose(s):

☐ Personal Use ☐ Coordinating Care ☐ Legal ☐ Disability ☐ Workers Comp

☐ Insurance/Benefits ☐ Other:_____

- I understand that I have a legal right to revoke this authorization at any time and I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **CIFC Health**. 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 my insurer with the right to contest a claim under my policy.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure healthcare treatment. I can contact the Privacy Officer if I have questions about my health information.
- This authorization **will expire 90 days after the date signed,** unless a different expiration is noted here:

By signing below, I acknowledge that I have read and understand this authorization form and that **CIFC Health** has 30 days to fulfill my request for copies of records.

Signature of Patient/Legal Representative: _____ **Date**: _____

Print Name: _____ **Relationship to Patient**: _____

CIFC Health Office Use *(only required when records are hand delivered.)* Date Received & Signed: ____ / ____ / ____

CIFC Health staff member verified the identity of the in-person recipient by: ☐ Photo ID ☐ Photo on file

Staff Name:_____ Signature:_____