HIPAA PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Atlas Healthcare Partners is the managing partner for all Corewell Health Surgery Center locations.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Release From (please specify location of services):

Facility Name: _____

Facility Address: _____

AUTHORIZATION

I hereby authorize **ATLAS HEALTHCARE PARTNERS** to disclose my medical information to the following recipient:

☐ Self (same information as above)

OR

☐ Entity/Individual (please specify)

Name of Entity or Individual: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

For Dates of Service:

From: _____/_____/_____ To: _____/_____/_____

MM DD YYYY MM DD YYYY

Information to be Released Pursuant to this Authorization:

☐ All of my health information (complete "designated record set" defined in 45 CFR 164.501)

☐ My health information relating to the following treatment or condition:

_____

☐ Billing Records: _____

☐ Specific documents: _____

☐ Other: _____

The Purpose of this Authorization is (check all that apply):

☐ Treatment/Continuing Care: ☐ Personal Use ☐ Billing or Payment ☐ Legal

☐ Other: _____

DELIVERY OF INFORMATION

Paper Request: ☐ Mail (via address listed above)

OR

Electronic Request: ☐ Encrypted E-mail: _____ (email address)

☐ CD (via address listed above) ☐ Fax: _____ (fax #)

NOTE: There is a level of risk that a third party could access your Protected Health Information (PHI) without your consent when faxed or when electronic media is unencrypted. We are not responsible for unauthorized access to faxes, unencrypted media or for any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in any electronic format.

MY RIGHTS AND UNDERSTANDING

- I understand that uses and disclosures already made based upon my original permission cannot be taken back. I further I understand that once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information may no longer be protected by federal privacy regulations, including HIPAA. I hereby release Atlas Healthcare Partners and its employees from any and all liability that may arise from the release of information as I have directed.
- I understand that I have the right to refuse to sign this Authorization. I understand that unless the purpose of this Authorization is to determine payment of a claim for benefits, signing this Authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- I understand that unless I revoke this authorization earlier, it will expire 12 months from the date signed. I understand that if this information is disclosed to a third party, the information may no longer be protected by State or Federal regulations and may be re-disclosed by the person or organization that receives the information.
- I understand I can withdraw my permission at any time by giving written notice to Atlas Healthcare Partners stating my intent to revoke this Authorization, except where uses or disclosures have already been made based upon my original permission.
- I understand that my health information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to, HIV or AIDS or other sexually transmitted infections and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse. Unless explicitly excluded in the above authorization, I give specific authorization for the release of these records.
- I understand that I have a right to receive a copy of this authorization.

_____ _____

Signature Check one: ☐ Patient ☐ Representative **Date**

If Legal Representative:

Print Name of Authorized Representative: _____

Relationship to the Patient /Authority of Representative to sign on behalf of the Patient:

☐ Parent of Minor ☐ Legal Guardian ☐ Court Order ☐ Other: _____

PLEASE COMPLETE THE FORM AND RETURN TO THE MEDICAL RECORD DEPARTMENT

Fax: 602-865-7795

Email: CHSC.MedicalRecords@atlashp.com

Mail: Atlas Healthcare Partners
Medical Records Department
2355 E Camelback Rd, Suite 700
Phoenix, AZ 85016