HIPAA AUTHORIZATION FORM

FOR RELEASE OF PROTECTED HEALTH INFORMATION

CARIEND

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security Number – last 4 digits only: _____

_____ Email address: _____

_____ Phone Number: _____

Limited/Specific Date(s) of Service for requested information (or enter "All"): _____

I hereby authorize Cariend to release my records from (name of original Provider/Facility that created the records):

_____

DO NOT EMAIL THIS FORM! **EMAIL REQUIRED FOR BOTH PERSONAL AND PROVIDER/THIRD PARTY!**

Release my records to: ☐ Myself via secure electronic transfer ☐ Provider or Third Party below (include full contact info)

_____

_____

Please release the following information in my medical record: ☐ Entire Medical Record (or select from list below)

If "Entire Medical Record" is checked, proceed directly to the signature line below

☐ History & Physical
☐ Consultation Report(s)
☐ Discharge Summary
☐ Operative Reports
☐ Emergency Room Record
☐ Laboratory Report(s)
☐ X-Ray/Imaging Report(s)
☐ Abstract or Summary

Other: _____

_____

(Optional) Please release the following information in my medical record (check all that apply):

I ☐ do ☐ do not want HIV/AIDS information release under this authorization.
I ☐ do ☐ do not want mental health information released under this authorization.
I ☐ do ☐ do not want drug/alcohol abuse or treatment information released under this authorization.
I ☐ do ☐ do not want genetic testing information released under this authorization.
I ☐ do ☐ do not want sexually transmitted disease information released under this authorization.

This authorization will expire within one (1) year unless otherwise indicated. I understand that this authorization is voluntary and maybe revoked by me at any time in writing except to the extent that action has already been taken in reliance with this authorization. I understand that my hospital/doctor's office may or may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits upon my authorization for this disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

YOU MUST PROVIDE A COPY OF PHOTO IDENTIFICATION WITH THIS FORM

DO NOT EMAIL THIS FORM!

_____

Signature of Patient or Patient's representative
(Representative must include proof of status)

☐ Parent/Guardian
☐ Personal Representative
☐ Legal Representative

_____

Request Date

FORM MUST BE COMPLETED IN ITS ENTIRETY OR REQUEST WILL NOT BE PROCESSED

IF MAILING: CARIEND - PO BOX 1866 - THOMASVILLE, GA 31799