Authorization to Disclose Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Client Name:______________________________________ Date of Birth:____________

Address:____ Phone: ________________

Parent/Guardian/Personal Representative (if applicable)

Name:____________________________________ Relationship to Client:____________

Address:____ Phone: ________________

AUTHORIZATION

I authorize ____ (healthcare provider) to use and disclose the above-named individual's protected health information to and used by the following person or organization:

Cascade Hemophilia Consortium

Name of person/organization authorized to receive the protected health information

517 W. William St, Ann Arbor, MI 48103 — Address

734-996-3300 phone/734-996-5566 fax — Phone Number

EXTENT OF AUTHORIZATION (please check box to indicate selection)

☐ I authorize the release of my Complete Patient File and Choice Consent Form (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my Complete Patient File and Choice Consent Form with the exception of the following information
(**Please select all that apply**):

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): ________________________________

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that if I give permission, I have the right to change my mind and revoke this authorization at any time. This must be in writing to the Facility or Program that maintains the individual's records that I authorized on this form. I also understand that any uses or disclosures already made with my permission cannot be taken back.

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If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that the above person/organization who would have received the information may have the right to contest health care coverage claims.

Unless otherwise revoked, this authorization will expire on: ____________ . If not specified, authorization will expire one year from date of signature below.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

By signing this authorization, 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 privacy rules. I further understand that I may request a copy of this signed authorization.

Signature of Client or Parent (if minor): ____

Signature of Guardian/Personal Representative (if applicable): _________________________________

Describe authority to sign on behalf of patient (eg, parent, legal guardian, health care power of attorney):

____

Printed Name: ____ Date: ____________________