Patient – Authorization for Disclosure of Protected Health Information (PHI) Health Insurance Portability and Accountability Act (HIPAA) Release

Form is used for a patient (or his/her personal representative) to authorize/direct noted PHI to be provided to a designated individual/entity. Concentra.com has contact information of active facilities for completed form submission. Contact the Privacy Office if visit was at a closed facility.

I authorize Concentra® to use and disclose protected health information (PHI) from the record(s) of:

Patient Name: ____________________ **Date of Birth:** ____________

Address: ____________________

Purpose of Disclosure: ____________________

Facility Visited: ____________________

Also note if applicable: Closed Site Onsite Telemedicine

Records to be disclosed related to the following date(s) of service: ____________________

Complete Medical Record Lab Results Physician Orders Prescriptions Itemized Bill X-ray

Other: ____________________

Confirmation of Who May Receive Copies of Patient Records

Person/Entity Name: ____________________

Address: ____________________ **City:** ____________ **St:** ___ **Zip:** ________

Fax Number: ____________ **Confirmation Phone Number:** ____________ **Email:** ____________

By Mail Call at Number to Pick Up Fax Secure Email [Mark an X here_____if unencrypted email preferred despite risk]

Other Electronic Method (USB, CD, Other); Please Specify: ____________________

In Connection With This Authorization

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficient Syndrome (AIDS). To authorize disclosure of **any of the following sensitive information initial the applicable line(s) below:**

Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Testing and/or Treatment

Sexually Transmitted Diseases Mental Health (Other than Psychotherapy notes)

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Concentra®, by providing a written request to the Center where my care was provided.

I understand that Concentra may not deny treatment if I do not complete this authorization form but may deny services when the services are only to create PHI for disclosure to a third party.

I understand that this authorization expires one year from the date of execution, unless revoked in writing, or a shorter expiration date is required by applicable state law.

I have a right to receive a copy of this authorization.

Patient Signature/Date: ____________ **Or Signature of Patient Representative/Date:** ____________

Printed Name of Patient Representative ____________________

Explanation of Legal Right to Sign for Patient: ____________________

For HIPAA questions related to this form, please contact the Concentra Privacy Office at 1-800-819-5571.

Concentra recognizes a patient's rights under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

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