ALSANA®

Alsana Medical Records Request

PATIENT INFORMATION:

Name: _____ **Date of Birth:** _____

I, _____, or my personal representative, request Alsana to release my protected health and mental health information to:

RECIPIENT INFORMATION (person or organization that will receive patient's information):

Name or Organization: _____ **Contact Type:** _____

Address: _____ **Phone:** _____

Email Address: _____ **Fax:** _____

1) I authorize Alsana to release the following information:

- ☐ Narrative account of my case history
- ☐ Social history
- ☐ Discharge summaries
- ☐ Substance/Alcohol Abuse information
- ☐ Sexually transmitted diseases (e.g., AIDS and HIV)

2) This Disclosure will be made for the following purpose:

_____

1. **READ CAREFULLY:** I understand that my medical and mental health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical and mental health information. The protected health information (PHI) in my medical and mental health record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse, which will only be released if specifically checked above.
2. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
3. I understand that I have the right to receive a copy of this authorization. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. 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 confidentiality rules. If I have questions about disclosure of my medical and mental health information, I can contact the health information management director (medical records director) or the Privacy Officer for this covered entity.

This information has been disclosed to you from records who confidentiality is protected by federal law. Federal regulations (42 CFR Part2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand and authorize the release of my PHI (personal health information) to the party specified above.

_____ _____

Signature Date