Instructions & Checklist
Authorization to Disclose Health Information

☐ This file contains:
(1) Instructions and Checklist for the Authorization to Disclose Health Information (the "Authorization");
(2) Information regarding the Authorization; and
(3) the Authorization.

☐ Complete the form, including any requested information.

☐ The patient or the patient's legal representative must sign and date the Authorization.

☐ This Authorization complies with the HIPAA Privacy Rules.

☐ Keep a copy of the Authorization for future reference.

☐ Laws vary from time to time and from state to state. This form is not intended to be and is not a substitute for legal advice. This form should only be a starting point for you and should not be used or signed before first consulting with an attorney to ensure that it addresses your particular situation. An attorney should be consulted before negotiating any document with another party.

Information
Authorization to Disclose Health Information

Your health and medical information is considered sensitive and private and is afforded protection under the law. However, there are circumstances when you may want to provide this information to another individual or entity (e.g. insurance companies, employers, etc.). In those circumstances, you will generally sign an authorization to disclose health information. These authorizations can be quite broad or quite limited.

This form of Authorization to Disclose Health Information allows you the flexibility to determine what types of information are to be released and under what circumstances. In addition, this form complies with the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rules

For more information on medical information privacy you can contact:

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C., 20201
Phone: (866) 627-7748
Web: www.hhs.gov

States may have different laws relating to the release of information, so you should become familiar with the laws of your state before using this form. In addition, before using this form you should consult with your attorney or physician to ensure that it addresses your specific situation.

Authorization To Disclose Health Information

Patient Name: _____ Health Record Number: _____

Date of Birth: _____ S.S. No.: _____

1. I authorize the use or disclosure of the above named individual's health information as described below. This information may be disclosed to and used by the following organization for the purpose of completing a Life Care Plan or Medicare Set-Aside cost projection:

Comprehensive Medical Case Management, LLC
344 Grove Street, #51
Jersey City, NJ 07302

2. The following individual or organization is authorized to make the disclosure:

_____

Address _____

_____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ❑ problem list
- ❑ medication list
- ❑ list of allergies
- ❑ immunization record
- ❑ most recent history and physical
- ❑ most recent discharge summary
- ❑ laboratory results from (date) _____ to (date) _____
- ❑ x-ray and imaging reports from (date) _____ to (date) _____
- ❑ consultation reports from (doctor's names)

_____

_____

_____

- ❑ entire record
- ❑ other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire when the Life Care Plan and Medicare Set-Aside cost projections, including associated litigation, has been completed.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand 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.

7. California/Arizona Restriction. I understand that a recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

8. You are further authorized to discuss my case in detail with
   _____

   _____

   or their representatives, and assist them in any way they may request your services.

9. I acknowledge receipt of a signed copy of this authorization
   _____ (Initials)

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Signature of Witness Date

Relationship to Patient:_____

A photocopy of this Authorization will be considered as an original.
This Release complies with the HIPAA Privacy Rules