thrive ALABAMA

AUTHORIZATION OF RELEASE OF PROTECTED HEALTH INFORMATION

R

PATIENT INFORMATION

Legal Name: Last _____ First _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ County _____

Phone _____ Social Security Number _____

RELEASE

Date of Request _____ Date Information Needed _____

❑ **I AUTHORIZE THRIVE ALABAMA**

TO RELEASE MY PROTECTED HEALTH INFORMATION IDENTIFIED BELOW TO

Name of Patient, Provider, or Facility _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Purpose for the disclosure _____

Specific description of information to be disclosed (including dates) _____

- I understand that I may change my mind and revoke (take back) this Authorization at any time in writing, except to the extent that the persons authorized above, have already acted based on this Authorization, as provided in the Thrive Alabama Notice of Privacy Practices.
- I understand that PHI disclosed based on this Authorization may be redisclosed by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law.
- I understand that PHI disclosed based on this Authorization may include mental health treatment, alcohol or drug abuse treatment and/or sexual health treatment including HIV/AIDS related information. I authorize release of all medical information concerning these diagnoses and/or treatment of these conditions, to the extent included in the records identified above.
- I understand that Thrive Alabama may not condition my treatment on my execution of this Authorization of Release of Protected Health Information.
- I understand that this Authorization expires one year from the date of signature, or sooner as indicated by date I write in here: _____.
- I acknowledge that Thrive Alabama (select one): ❑ **WILL** ❑ **WILL NOT** receive payment or other remuneration from a third party in exchange for using or disclosing my protected health information.

Signature _____ Date _____