Authorization to Release Health Records

Authorize Arbor Infusion Therapy to disclose your protected health information

PATIENT INFORMATION

LAST NAME | **FIRST NAME** | **MIDDLE INITIAL**

DATE OF BIRTH | **SEX** | **SOCIAL SECURITY NUMBER (LAST 4)** | **PHONE**

MAILING ADDRESS | **CITY** | **STATE / ZIP**

EMAIL ADDRESS | **PREFERRED CONTACT METHOD**

Information to be Disclosed

I authorize Arbor Infusion Therapy to release the following protected health information:

- ☐ Complete medical record (all dates of service)
- ☐ Records limited to date range below:
- ☐ Infusion administration records (visit notes, vital signs, medications administered)
- ☐ Lab results performed at or received by Arbor
- ☐ Insurance and billing records
- ☐ Imaging studies and reports
- ☐ Other (please specify):

DATE RANGE &MDASH; FROM | **DATE RANGE &MDASH; TO** | **OTHER / SPECIFY**

Authorization for sensitive health information. I specifically authorize the release of (check any that apply):

- ☐ Mental health information (excluding psychotherapy notes)
- ☐ HIV/AIDS-related information
- ☐ Substance use disorder records
- ☐ Genetic testing information
- ☐ I do NOT authorize release of any of the above categories

Recipient of Information

Records may be released to the following person or entity:

NAME OF PERSON OR ENTITY | **RELATIONSHIP** | **DATE NEEDED BY**

MAILING ADDRESS | **CITY** | **STATE / ZIP**

PHONE | **EMAIL** | **FAX** | **SECURE PORTAL NAME (IF KNOWN)**

Purpose of Disclosure

- ☐ Continuity of care with another provider
- ☐ Personal records
- ☐ Insurance or billing
- ☐ Legal proceedings
- ☐ Disability or workers' compensation
- ☐ Other (please describe):

OTHER PURPOSE &MDASH; PLEASE DESCRIBE

Your Rights & Expiration

I understand that:

- ☐ I may revoke this authorization at any time by submitting a written request to Arbor Infusion Therapy. Revocation will not apply to information already released in reliance on this authorization.
- ☐ Information released under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law.
- ☐ Arbor may not condition treatment, payment, enrollment, or eligibility for benefits on signing this authorization, except where permitted by law.
- ☐ I may inspect or obtain a copy of the information I authorize to be released.
- ☐ This authorization expires on the date specified below, or one year from the date of signature if no date is specified.

EXPIRATION DATE FOR THIS AUTHORIZATION | **OR SPECIFIC EVENT AFTER WHICH IT EXPIRES**

PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE	PRINTED NAME	RELATIONSHIP TO PATIENT (IF NOT SELF)	DATE

Form code: ARB-RELEASE-001 · Allow up to 30 days for processing of records release requests. A copy of this signed authorization will be provided to you upon request.