Sensitive Diagnosis/Authorization for Release of Information

If signed by legal representative, please provide representative documentation as required by state law, i.e. Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers.

Beneficiary name: _____

Beneficiary street, city, state, zip: _____

Beneficiary S.S. number: _____

I authorize the use or disclosure of the above-name beneficiary personal health information by ABC Healthcare Services and or ABC Health Plan, as describe below:
(ONLY ONE CHECK BOX BELOW IS ALLOWABLE PER FORM)

- ☐ Pregnancy & Birth Control Records
- ☐ Abortion Records
- ☐ AIDS & STDS Records
- ☐ Mental Health Records
  (Nature of Information, as limited as possible: _____)
- ☐ Alcohol & Drug Abuse Records
  (Nature of Information, as limited as possible: _____)

This information may be disclosed to, and used by, the following individual or organization:

Name: _____

Address: _____

The information is being disclosed for the following purpose(s):

- ☐ Personal Use
- ☐ Continued Medical Care
- ☐ School

☐ Insurance Claims

☐ Retirement/Separation

☐ Legal (Purpose of disclosure, as specific as possible)

☐ Other _____

By signing below, the beneficiary or the beneficiary's representative agrees to the following statements:

i. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

ii. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

iii. I understand that I may revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to ABC's Privacy Office to the address below. I understand that the revocation will not apply to information that has already been released in response to the authorization.

iv. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations

v. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the Regulations.

I understand that I may refuse to sign this authorization and that ABC may not condition treatment or payment on whether I sign this authorization. If no expiration date is specified then this authorization will expire one year from the date of signature.

Expiration Date

___ / ____ / ____

(MM) (DD) (YR)

Signature of beneficiary or beneficiary's representative: _____

Representative relation to beneficiary: _____

Signature of parent, guardian or authorized representative, when

required:_____

Date (MM/DD/YR)_____

(State and federal law commonly state that information related to alcohol/drug treatment, abortion, venereal disease, and/or AIDS cannot be disclosed without written consent of the patient/beneficiary. In some instances, information related to mental health and pregnancy/birth control may also require written consent of the patient/beneficiary. _____ (Physician name and/or Entity) will follow all Federal and state laws and regulations that are more stringent.)

Return completed form to (Physician and/or Entity address)

_____

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