Release of Information

Consent form

Patient Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip Code _____

Phone: _____ SS#: _____

I authorize the use or disclosure of personal and health information to Intercede Health as described below:

☐ Any and all personal and health information, including mental health, HIV, sexually transmitted disease and/or substance abuse records *(cross out any item you do not authorize to be released)*.

☐ Personal and health information regarding treatment for the following condition or injury: _____

_____

☐ Personal and health information covering this period of time: _____

This information may be disclosed to, and used by, Intercede Health, Inc., and their physicians, health providers, and staff expressly for the purposes of providing outpatient medical care services. I also authorize Intercede Health to disclose my personal and health information with the following:

Name: _____ Relationship: _____

Address: _____ City, State & Zip: _____

Phone: _____ Restrictions: _____

Name: _____ Relationship: _____

Address: _____ City, State & Zip: _____

Phone: _____ Restrictions: _____

I understand that I have the right to 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 Intercede Health. I understand that 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 Intercede Health when the law provides it with the right to contest a claim under my policy. Unless otherwise revoked, **this authorization will expire in 365 days.**

I understand that I do not have to sign this authorization and the Intercede Health may not condition treatment or payment on whether I sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I have read the above or have had it read to me and accept the terms of the Release of Information Consent Form. I do understand that Intercede Health is a Physician Practice providing outpatient medical care to patients diagnosed with one or more chronic diseases.

Signature of Patient: _____ Date: _____

Signature of Legal Representative:** _____ Date: _____
(only if member is unable to sign):

If signed by a Legal Representative, relationship to patient: _____

** *If signed by a Legal Representative, you must provide documentation required by state law, i.e. Healthcare Power of Attorney, Health Care Surrogate, Living Will or Guardianship paper.*