

Authorization to Release Health Records

Authorize Ascribe 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 Ascribe 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 Ascribe Infusion
- ☐ Insurance and billing records
- ☐ Imaging studies and reports
- ☐ Other (please specify):

DATE RANGE &MDASH;

DATE RANGE &MDASH;

FROM

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 Ascribe 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.
- ☐ Ascribe Infusion 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: ASC-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.