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Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN (optional)**

CarePartners Service Line: ❑ Home Health ❑ Hospice ❑ PACE ❑ Palliative Care ❑ Private Duty ❑ Other _____

CarePartners Provider Address:

Recipient/Facility Name		**Recipient's Phone:**	
Address 1:		**Recipient's Fax Number:**	
Address 2:	**City:**	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ❑ **Paper Copy** ❑ **Electronic Media, if available (e.g., CD/DVD)**
❑ **US Mail** ❑ **Pick-up** ❑ **Encrypted Email** ❑ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.,* paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.,* virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire after 180 days or on the following (please choose only one):
Expiration Date: **Expiration Event**:

Purpose of disclosure: ❑ **At the request of the individual; or** ❑ **Other 3rd party recipient (please specify purpose):** _____

Description of information to be used or disclosed

Is this request for psychotherapy notes? ❑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ❑ No, then you may check as many items below as you need.

Description:	*Date(s):*	*Description:*	*Date(s):*	*Description:*	*Date(s):*
❑ All PHI in medical record		❑ Assessments/Evaluations		❑ Itemized bill: _____	
❑ Discharge Summary		❑ Treatment Plans		❑ UB-04: _____	
❑ History and Physical		(POT/Certification/Care Plan)		❑ Other: _____	
❑ Medical Progress/Visit Notes		❑ Provider Orders		❑ Other: _____	
❑ Lab Reports		❑ Treatment/Visit Notes		❑ Other: _____	
❑ Radiology Reports		❑ Therapy/Clinical Summaries		❑ Other: _____	
		❑ Nursing/Clinical Summaries		❑ Other: _____	

For USCDI Release Requests: to include all elements as defined in the United States Core Data for Interoperability.
Requires Direct Address or National Provider Identifier:

All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. Specify any information you want to exclude: _____

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ❑ Yes ❑ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ❑ Yes ❑ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ❑ Yes ❑ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

ID verified by: _____ (initials)

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CCP-04640-115-1021

CarePartners
Rehabilitation | Home Health | Adult Care | Hospice
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