Authorization for Sharing Information

IHA Our family caring for yours!

OFFICE NAME: _____

1. THINGS YOU SHOULD KNOW (PRIVACY NOTICES):

a) You should know that **if using a policyholder/parent's health insurance** plan for services, IHA and the insurance company may share your information to the policyholder/parent for services you have performed. **In addition**, **they would receive an explanation of benefits**, **and may gain access to medical and billing information about your visit.**

b) Understand that this consent **will be in effect** until you withdraw it in writing **or** for the **period specifically listed** here: _____. Further, you should understand that you may opt out of this type of release of information by providing written notice to your physician. ***You have to tell us in writing if you want to change your proxy.*** (person-designated by you to have access to your portal and healthcare information).

c) If you give permission to share your health information with another person, that person could **re-disclose** your health information and your information is no longer protected by Federal privacy regulations. Your health care will not be affected if you do not sign this form. ***When we share information with others, they may be able to share it with others.***

This is where you (the patient) fill in YOUR information.

2. PATIENT: _____ / _____

LAST NAME FIRST NAME MI MAIDEN OR OTHER NAME DATE OF BIRTH

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT PHONE NUMBER(S): _____

EMAIL: _____

This is where you fill in the WHO you are allowing to get your information.

3. I CONSENT to share my health information with the following individual(s) involved in my care:

NAME: _____ DATE OF BIRTH: _____ (If Available)

ADDRESS: _____

PHONE: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ DATE OF BIRTH: _____ (If Available)

ADDRESS: _____

PHONE: _____ RELATIONSHIP TO PATIENT: _____

This is where YOU decide if you authorize IHA to share your information as listed below.

4. I AGREE/DECLINE to share the following information: *(THIS AUTH APPLIES TO ALL IHA OFFICES)*

NOTE: *IF YOU DECLINE TO SHARE ALL OR SPECIFIC INFORMATION, WE CANNOT ADD A CARE MANAGER TO YOUR PATIENT PORTAL.*

INITIAL BY YOUR CHOICE HERE

☐ **I AGREE** to share/release all relevant information, ***INCLUDING release of all the following.***

Special consent information: *HIV (Human Immunodeficiency Virus) related illness, testing OR Sexually Transmitted Diseases; AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex); Information about Alcohol and Drug Abuse Treatment; Information about Mental Health Services and Social Services. In addition, other private information such as pregnancy or contraceptive management information can be shared.*

☐ **I AGREE** to share/release all relevant information, ***EXCLUDING special consent areas above***.

☐ **I AGREE** to share/release ***ONLY*** this specific information: _____

☐ **I DECLINE** to share/release my health information.

_____ OR _____

SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN DATE