Altair Health

Authorization for Use & Disclosure of Protected Health Information

Please fax this form to (973) 285-7809 or deliver to 310 Madison Ave, Suite 300 · Morristown, NJ 07960

PATIENT IDENTIFICATION:

Name: _____ Date of Birth: _____

Street Address: _____ Tel # (cell): _____

City, State ZIP: _____ Tel # (alternate): _____

Email Address: _____ Physician: _____

DISCLOSURE:

I request my records to be delivered by: ☐ Electronic Delivery ☐ Mail (paper) ☐ Pick Up (paper) ☐ Fax to Healthcare Provider

I hereby authorize Altair Health to disclose my Protected Health Information to:

Facility/Individual Name: _____ Relationship: _____

Attention: _____ Fax #: _____

Street Address: _____ Tel #: _____

City, State ZIP: _____ Email Address: _____

PURPOSE OF REQUEST: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ _____

TREATMENT DATES: for Information to be released: **From (date):** _____ **To (date):** _____

TYPE OF INFORMATION TO BE RELEASED:

☐ Office Notes ☐ Complete Health Record ☐ Radiology Reports ☐ Labs

☐ Physical Therapy Notes ☐ Itemized Billing Statement ☐ X-ray, MRI, Images (on disc only) ☐ Other: _____

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE: I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check one:*** ☐ Yes ☐ No

TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION: Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of Health Information Systems or other Department to whom you are authorizing. **This Authorization will expire on (date)_____, or 90 days from signature date**.

RE-RELEASE: I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

COST OF MEDICAL RECORD COPIES: Medical record copies for personal use delivered directly to the patient, or for treatment (excluding patient transfer) delivered directly to a healthcare provider are at *no charge*. Medical record copies for all other purposes will be charged at *applicable rates* with payment due in advance and payable to Resolve*ROI*, and requests for X-ray, MRI or images on disc are *$20 per disc* (+ delivery cost). **For questions regarding this request please contact Resolve*ROI* at (844) 887-8109 or Support@ResolveROI.com**.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE: By signing below, you authorize your healthcare provider identified above to release your protected health information and acknowledge and understand the terms of this Request for Access to and Authorization for Use and Disclosure of Protected Health Information. This consent permits Altair Health to use and disclose my protected health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of protected health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, Altair Health is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE Altair Health, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

Print patient's name: _____

Signature of patient or legally authorized person: _____ **Date:** _____

Relationship to Patient: _____