# Patient Authorization for Release of Health Information

ocli.net | 1-833-509-OCLI (1-833-509-6254)

Name: _____ Date of Birth:_____

Street Address: _____ Apt: _____

City: _____ State___ Zip_____ Phone: _____

Email Address: _____

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**1. Contact information of health care provider or entity to release this information:**

Name: _____Address: _____

Phone: _____Fax: _____

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**2. Contact information of person(s) or entities who will receive this information:**

Name: _____Address: _____

Phone: _____Fax: _____

Email Address: _____

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**3. Specific information to be released:**

☐ Abstract (summary of the record)

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record

☐ Laboratory results from date of service _____

☐ Other _____

The following types of information will NOT be released unless you or your authorized representative initial in the appropriate spaces provided below:

_____Substance Abuse Information

_____Mental Health Information

_____HIV-Related Information

_____Genetic Testing Information

Copy 1- Patient Medical Record
Copy 2- Patient or Patient's Personal Representative

**4. Method of delivery for release of information:**

☐ Pick-up at Central Business Office

☐ Pick-up at facility

☐ Patient Portal (Must have active account)

☐ Mail

☐ Fax

☐ USB Flash Drive

☐ Secure Email

☐ Unencrypted E-mail (Must complete page 4)

☐ Verbal_____ **Please initial here** to authorize the person or a representative from the entity specified in Part 1 to discuss the health information being released under this Authorization with the person, or representative from the entity, specified in Part 2.

Other method of delivery (please explain) _____

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**5. Reason for release of information:**

☐ At request of individual

☐ Legal Matter

☐ Other: _____

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**6. I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as stated on this form. In accordance with State Law, 42 CFR Part 2 and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:**

**I reserve the right to revoke this Authorization and my Consent to Send Information Requested by Unencrypted E-mail (page 4 of this document) at any time by writing to the health care provider listed in Part 1. I understand that I reserve the right to revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization.**

**I understand that signing this Authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.**

**I understand that information disclosed under this Authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law. However, if I am authorizing the release of substance abuse treatment, mental health treatment, HIV-related treatment, or genetic testing information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.**

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**7. Date or event on which this Authorization will expire:** _____

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**8. Signature of Patient or Authorized Representative**

_____ _____

Signature of Patient or Authorized Representative — Date

_____

Printed Name of Patient or Authorized Representative

_____

If signed by Authorized Representative, Relationship to Patient

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**Only for use when interpreter services are utilized for the completion of this form:**

_____ _____

Telephonic Interpreter's ID # — Date/Time

_____ _____

Signature: Interpreter — Date/Time

_____

Print: Interpreter's Name and Relationship to Patient

_____ _____

Witness to Signature — Print Witness Name

Copy 1- Patient Medical Record
Copy 2- Patient or Patient's Personal Representative

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## Consent to Send Requested Information by Unencrypted E-mail

If you are requesting health information (pursuant to the attached Authorization Form) be released via unencrypted E-mail, you shall acknowledge and consent to the following:

Unless I request otherwise, E-mails containing health information sent to me from OCLI or its affiliate are encrypted to keep them secure during transmission. I acknowledge and understand that most personal E-mail services do not encrypt or otherwise protect E-mails and, therefore, I understand that E-mail sent unencrypted means others may be able to access the information and read it once it is transmitted over the Internet. Despite this risk, I authorize my provider to transmit the information I have requested by unencrypted E-mail.

I further acknowledge that E-mails may be inadvertently sent to the wrong address and may be subject to technical malfunctions. Therefore, I understand that E-mail delivery is not guaranteed and potentially subject to unauthorized disclosure to third parties.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name of Patient or Authorized Representative

_____

If signed by Authorized Representative, Relationship to Patient

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**Only for use when interpreter services are utilized for the completion of this form:**

_____ _____

Telephonic Interpreter's ID # Date/Time

_____ _____

Signature: Interpreter Date/Time

_____

Print: Interpreter's Name and Relationship to Patient

_____ _____

Witness to Signature Print Witness Name

Copy 1- Patient Medical Record
Copy 2- Patient or Patient's Personal Representative