# Think Whole Person Healthcare
# **Authorization to Release and/or Receive Records**

Patient name

DOB | SSN | Tel

Address

**I hereby authorize Think, and/or its affiliates, to:**

- ☐ **Release** copies of billing or medical records to the following persons or entities
- ☐ **Receive** copies of billing or medical records from the following persons or entities

Information shall be obtained and/or released pursuant to this Authorization for the last:

☐ 1 Year ☐ 2 Years ☐ 5 Years

Please select what information shall be obtained and/or released pursuant to this Authorization:

- ☐ Immunizations
- ☐ Lab/Pathology Reports
- ☐ Radiology Images
- ☐ Hospital Reports
- ☐ Other
- ☐ Billing Information
- ☐ Clinical Chart
- ☐ Alcohol/Substance Abuse
- ☐ HIV/AIDS/Communicable Diseases

*Information may be released in writing, verbally, or by video, fax, photocopy, or microfilm.*

**NOTICE TO PATIENT/PATIENT REPRESENTATIVE: If the recipient of the information disclosed pursuant to this Authorization (other than alcohol/substance abuse information) is not a health care provider, health plan or health care clearinghouse, the information may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws and regulations. Recipients of alcohol/substance abuse information are required by law to obtain your written consent before redisclosing such information.**

The information will be obtained and/or disclosed for the following reason(s):

- ☐ Treatment/Continuity of Treatment
- ☐ At the Request of the Individual
- ☐ Marketing*
- ☐ Legal Reasons
- ☐ Assessment & Evaluation
- ☐ Other

**Think and/or its affiliates will not receive compensation, whether monetary or otherwise, as a result of the use or disclosure of this information for marketing purposes.*

This authorization will expire:

- ☐ 90 days from the date of the signature below, or
- ☐ Other

This authorization may be revoked by notifying Think in writing addressed to:
**John R. Jacobsen, M.D., Privacy Officer,**
**7100 West Center Road, Omaha, NE 68106**
**hipaa@thinkhealthcare.org**

Note: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by Think and/or its affiliates.

4828-5854-9028.1

**NOTICE TO RECIPIENTS OF ALCOHOL AND/OR SUBSTANCE ABUSE INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

| Patient Signature: | Date: |
| --- | --- |
| Personal Representative's Signature: | Date: |
| Personal Representative's Relationship/Authority: | Date: |

**This authorization is voluntary.** If the patient refuses to sign, his/her refusal will **not** affect his/her ability to obtain treatment, payment, or, if applicable, enrollment in a health plan or eligibility for benefits. A photocopy or fax of this release shall be as valid as the original.

**Please return this form via fax to: 1-402-506-9093**
**or via email to: info@thinkhealthcare.org**

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