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AUTHORIZATION TO RELEASE MEDICAL INFORMATION FORM

Member whose Medical Information is to be Released and Authorized Recipients:

Member Name (First, Middle Initial, Last) ____________________ Date of Birth ____________

I authorize my Medical Information to be released to the following named individuals:

Name	Relationship

For the following purpose: To keep the individual(s) informed about my care, payment for my care, and administration of my Medivest account.

WHAT MEDICAL INFORMATION MAY BE DISCLOSED? I authorize the disclosure of all of my medical services, medical insurance(s), payment records, and medical records regarding any medical or mental health condition, including, but not limited to:

- Consultation information
- Demographics
- Discharge summaries
- Problems and diagnoses
- History and physical examinations
- Care plan and health care providers
- Medication lists, allergies, and immunizations
- Visit, treatment, and progress notes
- Assessments
- Lab/pathology reports
- Operative reports
- Developmental disability
- Radiology reports and films
- Information about mental illness
- Information about substance abuse
- Sexually transmitted diseases
- HIV/AIDS
- Abortions
- Genetic testing and results
- Problems and diagnoses
- Consultation information
- Demographics
- Discharge summaries

I understand that I am authorizing the release of medical information created before and after the date of this authorization. My authorization is voluntary and is not a condition of eligibility for benefits or payment of claims.

POTENTIAL FOR RE-DISCLOSURE: I understand that some or all of the medical information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, in which case such information would no longer be protected by the HIPAA Privacy Rule.

RIGHT TO WITHDRAW AUTHORIZATION: I understand that I may withdraw this authorization at any time by giving written notice to Medivest. My revocation will be effective on the date Medivest receives my revocation. I understand that my revocation will not apply to any information already released as a result of the permission I granted in this authorization or to any other authorization I grant(ed) to Medivest.

EXPIRATION: This authorization will remain in effect until either: **(1)** the date my Medivest account closes, *or* **(2)** the date I revoke this authorization.

I read and understand this authorization and had the chance to ask questions about the disclosure of my medical information. I understand that I may keep a copy of my signed authorization and that a copy is as valid as the original.

Signature of Member	Printed Name	Date
Signature of Legally Authorized Representative (if any)	Printed Name	Date

Authorized Relationship to Member: ☐ Mother ☐ Father ☐ Spouse ☐ Legal Guardian ☐ Power of Attorney