



AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I authorize Advocare, LLC to disclose the following information from the medical records of:

Patient Information:

(Print) Patient Name: _____ Date of birth: _____

Address: _____

Phone Number: _____ Patient SS#: _____

Covering the period(s) of health care: From: _____ To: _____

Information to be disclosed:

Select from the following (check all which apply):

☐ Complete health record(s), excluding all images

OR

☐ Discharge Summary

☐ Progress Notes

☐ History and Physical Examination

☐ Laboratory Tests

☐ Consultation Reports

☐ X-ray reports

☐ Mental health care or services

☐ Photographs, videotapes,
digital or other images

☐ Treatment for alcohol and/or drug abuse

☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human
Immunodeficiency Virus) infection

☐ Other (please specify): _____

This information is to be disclosed to the individual or entity identified below for the purpose of:

Release Records To:

Name: _____ Relationship: _____

Address: _____

Phone Number: _____

By signing this form, the Patient or Patient's Legal Representative attests to reading and accepting the following statements:

1. I understand that unless earlier revoked, this authorization expires on __/__/20__ or on the happening of _____.
(If no expiration date is designated this authorization will expire six (6) months from the signature date.)
2. I understand that I may revoke this Authorization at any time by notifying Advocare, LLC in writing, but if I do so my revocation will not have any effect on any actions Advocare, LLC took in reliance on this Authorization before it received my revocation.
3. I understand that Advocare, LLC cannot make me sign this Authorization as a condition to receive treatment from Advocare, LLC:
 - i. When Advocare, LLC provides me with research related treatment; or
 - ii. When Advocare, LLC provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

Advocare, LLC, its providers, employees, members and agents are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

Signature of Patient or Legal Representative: _____

Print Name: _____ Dated: _____

If Signed by Legal Representative, state relationship to Patient: _____

Note: If you are the Patient's Legal Guardian other than a parent, or if you are the Patient's Power of Attorney, a copy of the legal document granting you such power must be attached to this request.