RELEASE OF INFORMATION

alivation HEALTH

Patient Name_____Date of Birth_____

Please check the following: ☐ Behavioral Health ☐ Primary Care ☐ Neurology

I hereby authorize Alivation Health, LLC to provide and receive information for the following person(s) or organization(s):

Name	Relationship to Patient	
Address		
Phone	Fax	Email

Purpose of Request (check only one):

☐ Coordination of Care ☐ Transfer of Care ☐ Personal ☐ Attorney/Legal ☐ Other _____

I request my records be provided by the following means (check only one):

☐ All (Includes: Email, Fax, Voice & Paper Copy)

☐ Other _____

Please check the dates (check only one):

☐ All previous dates ☐ From (Date)_____To(Date)_____

Please check the type of information to be released (check only one):

☐ All (Includes: Encounters, Labs, Questionnaires, Scheduling, Financial, Medications, & Orders)

☐ Other_____

Expiration Date: I understand that this authorization shall be in force and effect until ☐ (state the specific expiration date or the event triggering the expiration) at which point the authorization will expire. If left blank, release will automatically set to expire one year from the date signed.

Check Yes or No: ☐ ☐

Drug and/or Alcohol Abuse, and/or Psychiatric and Communicable-Non-communicable Diseases: I understand my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases (such as hepatitis, gonorrhea), psychiatric care, drug and alcohol abuse/treatment, or other sensitive information. I agree to its release. Check yes or no.

Revocation of Authorization: I understand that I may revoke this authorization at any time by sending written notification to Alivation Health, 8550 Cuthills Circle Lincoln, NE 68526. I understand that a revocation is not effective to the extent that the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Authorization for Marketing: I understand that the authorized use or disclosure will result in a direct or indirect payment to the providing organization from a third party. (This section is necessary only if the authorization is for marketing purposes and involves direct or indirect payment to the covered entity from a third party).

Conditioning of Authorization: I understand that the providing organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on me providing an authorization for the request use or disclosure. Unless my treatment is 1) related to the research, 2) my health care services are provided solely for creating protected health information for disclosure to a third party, or 3) if the authorization is sought for a health plan to determine eligibility or enrollment for underwriting purposes.

Signature of Patient/ Legal Guardian	Date
Guardian Name If Applicable	

OFFICE USE ONLY

Alivation Health, LLC Witness Print Name	Date
Action Needed (write "none," if none)	