Authorization for Sharing Information

1. THINGS YOU SHOULD KNOW (PRIVACY NOTICES):

a) You should know that **if using a policyholder/parent's health insurance** plan for services, IHA and the insurance company may share your information to the policyholder/parent for services you have performed. **In addition**, **they would receive an explanation of benefits**, **and may gain access to medical and billing information about your visit.**

b) Understand that this consent is for all IHA/SJMG locations and **will be in effect** until you withdraw it in writing **or** for the **period specifically listed** here: _____. Further, you should understand that you may opt out of this type of release of information by providing written notice to your physician.

c) If you give permission to share your health information with another person, that person could **re-disclose** your health information and your information is no longer protected by Federal privacy regulations. Your health care will not be affected if you do not sign this form. ***When we share information with others, they may be able to share it with others.***

This is where you (the patient) fill in YOUR information.

2. PATIENT: _____ / _____

LAST NAME | FIRST NAME | MI | MAIDEN OR OTHER NAME | DATE OF BIRTH

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT PHONE NUMBER(S): _____

EMAIL: _____

This is where you fill in the WHO you are allowing to get your information.

3. I CONSENT to share my health information with the following individual(s) involved in my care:

NAME: _____ DATE OF BIRTH: _____ (If Available)

ADDRESS: _____

PHONE: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ DATE OF BIRTH: _____ (If Available)

ADDRESS: _____

PHONE: _____ RELATIONSHIP TO PATIENT: _____

This is where YOU decide if you authorize IHA to share your information as listed below.

4. I AGREE/DECLINE to share the following information: *(THIS AUTH APPLIES TO ALL IHA OFFICES)*

INITIAL BY YOUR CHOICE HERE

☐ **I AGREE** to share/release all relevant information, ***INCLUDING release of all the following.***

Special consent information: *HIV (Human Immunodeficiency Virus) related illness, testing OR Sexually Transmitted Diseases; AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex); Information about Alcohol and Drug Abuse Treatment; Information about Mental Health Services and Social Services. In addition, other private information such as pregnancy or contraceptive management information can be shared.*

EXCLUSION - Records excluded from disclosure are those that meet the requirements for CFR 42 Part 2 and require a separate consent for release.

☐ **I AGREE** to share/release all relevant information, ***EXCLUDING special consent areas above***.

☐ **I AGREE** to share/release ***ONLY*** this specific information: _____

☐ **I DECLINE** to share/release my health information.

_____ OR _____

SIGNATURE OF PATIENT | DATE | PARENT/LEGAL GUARDIAN | DATE

PRESENTED ID: _____ **PROOF OF LEGAL GUARDIANSHIP (when applicable):** _____

PROCESSED BY THE FOLLOWING LOCATION: _____

STAFF INITIALS: _____ **DATE:** _____