Trinity Health
IHA Medical Group

Authorization for Sharing Information

- This consent applies to all Trinity Health IHA Medical Group locations and will remain in effect until revoked in writing, or for a specific time period indicated below.
- Submitting a new Authorization to Share form automatically replaces any previous version on file.
- You may opt out at any time by submitting a written request to Trinity Health IHA Medical Group .
- If you authorize us to share your information, that information may no longer be protected by federal HIPAA privacy laws once shared.
- Your health care will not be affected by your decision to sign or not sign this form.
- If you use a parent or policyholder's health insurance, IHA and the insurer may disclose information (including explanations of benefits) to the policyholder.

Step 1: To be completed by patient/legal guardian:

Last	First	MI	Date of Birth
Contact Phone Numbers			Zip Code

Step 2: Person(s) you authorize Trinity Health IHA Medical Group to verbally share your health information with: *(This Authorization Applies to All Trinity Health Offices)*

1. **NAME:**_____DATE OF BIRTH:_____(If known)

   PHONE:_____RELATIONSHIP TO PATIENT: _____

2. **NAME:**_____DATE OF BIRTH:_____(If known)

   PHONE:_____RELATIONSHIP TO PATIENT: _____

3. **NAME:**_____DATE OF BIRTH:_____(If known)

   PHONE:_____RELATIONSHIP TO PATIENT: _____

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/treatment for 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, Pregnancy or Contraceptive management information.*

☐ **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 (in the event of a serious or life-threatening situation your emergency contact may be contacted)

_____OR _____

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