AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM QUADMED AND AN ASSOCIATED CLINIC

1. **Patient Information:**

_____

Last *MI* *First* *Date of Birth*

_____

Address *City* *State* *Zip*

_____

Cell Phone *Home Phone* *Email*

2. **I authorize information to be released from QuadMed, LLC and _____ (*the clinic name must be entered*) to the following recipient:**

_____

Name/Facility

_____

Address *City* *State* *Zip*

_____

Phone *Fax*

3. **Preferred method of delivery:**

☐ US Mail ☐ Fax: _____ Attention to: _____

☐ Email: _____

Pick Up: ☐ Self ☐ Authorized Individual: _____

Relationship: _____

Clinic location: _____

4. **Information to be disclosed:**

☐ Provider Notes of Medical History, Examination Progress or Discharge
☐ Immunizations ☐ Tests and Results ☐ Radiology Reports
☐ Consultations ☐ Laboratory Reports ☐ Prescriptions
☐ Other (specify):_____
☐ Entire Record (specific justification): _____

The following information WILL NOT be released unless specifically checked below:

☐ Alcohol/drug abuse treatment ☐ Mental health
☐ HIV test results and related treatment ☐ Developmental disabilities
☐ Sexually transmitted or other communicable diseases ☐ Genetic

5. **Date(s) of information to be disclosed**:
From: _____To:_____. *If left blank, only information from approximately the past two (2) years will be disclosed.*

6. **The purpose of this release is:**

☐ Transfer of care ☐ School use ☐ Litigation/legal ☐ Personal use or review
☐ Continuing care ☐ Insurance eligibility/benefits
☐ Other (please specify): _____

7. **Your Rights with Respect to this Authorization:** I understand that this Authorization is voluntary. I may revoke this Authorization by providing my revocation by notifying QuadMed in writing, except to the extent that action has been taken in reliance upon my Authorization. I understand that information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws. I understand that QuadMed may not condition treatment, payment, enrollment or eligibility for benefits upon execution of this Authorization unless the services are being provided solely for the purpose of disclosing the information to a third party. I also understand that QuadMed may have the right to impose a reasonable, cost-based fee for copying, postage and preparation of records associated with fulfilling this request. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the Authorization.

8. **Expiration:** This Authorization expires on _____ *(insert date, time period or event).* Unless otherwise specified, this Authorization will expire one year from the date of my signature below.

9. **Signature:** By signing this Authorization, I am authorizing the release of all records applicable to this request as outlined above.

_____ _____

Signature *Date*

If signed by a Legal Representative, complete the following:

1. The Individual is: ☐ A minor ☐ Legally incompetent or incapacitated ☐ Deceased
2. Legal authority: ☐ Parent* ☐ Legal guardian ☐ Next of kin/executor of deceased ☐ Activated POA for health care

** By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.*

_____

TO BE COMPLETED BY QUADMED

Method of request delivery:
☐ Patient
☐ Mail
☐ Fax
☐ Individual other than patient:
☐ Confirmed request with patient, by: _____
(Name of QuadMed representative)

The requested information was sent via:
☐ U.S. Mail
☐ Fax
☐ Secure Email
☐ Picked up by: _____ ☐ Identity Verified
(Name of Patient or Authorized Individual)

Released by: _____
(Name of QuadMed representative)

Date of release: _____

In select states, patient care is provided by an independent physician-owned corporation.

Authorization for Release of Protected Health Information From QuadMed and an Associated Clinic
INSTRUCTIONS

The authorization form is not valid if one or more required elements are left blank. Failure to complete all required elements may result in a delay in processing your request. You may fax your completed form to (414) 566-9161, email it as an attachment to MedicalRecords@quadmedical.com, or return it to the clinic in person.

Section 1: Fill in your complete name, date of birth, address, contact phone number, and email address.

Section 2: Fill in the name, address, and telephone number of the individual or organization that you want to receive your information.

Section 3: Select the preferred method of delivery. If you would like QuadMed/Clinic to send the records to the recipient, select if the records should be sent by "Mail" or "Fax" and fill in the line stating who the mail or fax should be directed to ("Attention to: _____"). Check "Self" if you will be receiving the records. If you wish to send a family member or other person to pick up the records, provide that person's name in the "Authorized Representative" line and note their relationship to you on the "Relationship" line. Please note that a photo ID will be required in all cases. If you pick up your own records, please be prepared to show your ID. If you name someone else to pick up your records, please make them aware they will need to show their photo ID.

Section 4: Check as many boxes as you need in order to indicate what information should be disclosed. If you desire to disclose only limited records or records for a certain episode of care but those records are not described in the available check boxes, check the "Other" box and provide a description of what information should be disclosed. If all records listed in this section are needed, simply check the "Entire Record" box and provide a short explanation of why you are requesting your entire record. If you need assistance, please ask the QuadMed staff for assistance. You may also review your record before completing this form in order to determine what should be disclosed.

If you want any of the following information disclosed, you must check the box indicating each type of information that you want disclosed: alcohol/drug abuse treatment, mental health, HIV test results and related treatment, developmental disabilities, sexually transmitted or other communicable diseases, and genetic.

Section 5: Enter the beginning and ending dates of the information you wish to be disclosed. If you leave these dates blank, only approximately the past two (2) years of information will be disclosed.

Section 6: Check the box or boxes that most closely described the purpose of the disclosure. If none of the boxes apply, check "Other" and write in the purpose.

Section 7: This section explains your rights under the law, and includes a notice that the party receiving your records may not be required by law to keep those records confidential. Please note a fee may be charged for record copies.

Section 8: Fill in the date you wish this authorization to expire. If you leave this blank, the authorization will automatically expire in one year. You may also list an event.

Section 9: Sign and date here if you are the patient. If you are the legal representative of the patient, sign and date here and also indicate 1) your relationship to the patient, and 2) your legal authority to act on the patient's behalf. If you check "parent," and sign this form, you are declaring that you have not been denied physical placement of the minor child by a court of law or had your parental rights terminated by a court order.