Putting HEALTH back in Healthcare!

REQUEST TO ACCESS, INSPECT, OR OBTAIN PROTECTED HEALTH

Medical records are kept in strict confidence and are not released without the written authorization of the patient except as permitted or required by law. I understand that A New Direction Health & Wellness providers have 30 days to respect this request. I understand these records may contain information created by other persons or entities; including other healthcare providers as well as information regarding the use of drug and alcohol treatment services; HIV/AIDS treatment, mental health services (excluding psychotherapy notes); reproductive health services and treatment for sexually transmitted diseases.

Authorization for Use and Disclosure of Information

Patient Name: ______________________________________ Date of Birth: ________________________

Patient Street Address: ____

City, State, and Zip: ____

Patient Telephone Number: ____

Patient Email: ____

Release Information to:

☐ Insurance ☐ Healthcare Provider ☐ Self ☐ Other: _______________________________

Name/Business: ____

Address: ____

City, State, and Zip: ____

Phone Number: _____________________________ Fax: ________________________________

Email: ____

Information to Be Used and Disclosed

Requested Timeframe for Records. Dates of Service From: ____________________ To: ____________________

Requested Records:

☐ Entire Medical Record ☐ Diagnosis/Treatment Notes ☐ Lab/Xray(s) ☐ Physical Forms

☐ Payment Information ☐ Immunization Records ☐ Referral

☐ Other: ____

Purpose of the Use and Disclosure

☐ Diagnosis & Treatment ☐ Insurance/Billing ☐ Legal ☐ Personal

☐ Other: __________

Method for receiving your health information: (check only one box below)

☐ Paper

☐ Email (Encrypted). In an effort to protect your health information, our standard practice is to encrypt our email.

☐ Email (Unencrypted) Signature Required. By signing you acknowledge that you understand an unencrypted email exposes your personal and health information to additional security risks.
Signature______________________________

If you require your health information in a format other than paper or email, please contact us at the number listed above. We may be able to accommodate your request at an additional charge.

Patient Agreement:

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or entity I authorize to receive the information is not my healthcare plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form. I release A New Direction Health & Wellness providers and each of their respective subsidiaries, affiliated companies, directors, officers, employers, employees, attorneys, and agents from all legal responsibility and/or liability that may arise from the release of the records I have specified. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken with reliance on it. I authorize A New Direction Health & Wellness to use or disclose protected health information as described above.

I understand I may access and review health information held about me in the A New Direction Health & Wellness "designated record set" in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand this information may be accessed and reviewed by accessing my patient fusion account.

I understand that A New Direction Health & Wellness has 30 days to respond to this request. I also understand that A New Direction Health & Wellness may extend this 30 day response period for an additional 30 days. I further understand that in certain circumstances A New Direction Health & Wellness may deny my request.

I agree to pay any fees for use and disclosure of my health information. Fees will be reasonable and cost-based, and include only the cost of copying and postage.

I understand that this request does not apply to certain health information, including: (1) information that is not held in the designated record set; (2) information compiled in reasonable anticipation of or for litigation; and (3) other information not subject to the right to access information under HIPAA.

Note: If you are signing this form as the legal representative of the individual listed above, and are other than the parent of the minor child whose information is listed above, you must also submit documentation that establishes yourself as the legal representative. For

example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc. A copy of a Photo ID will also be required.

Client or Client Representative Printed Name: ____

Client or Client Representative Signature: ____

Relationship to Client: ____

Date: ________________

Time: _______________ **AM/PM**