CenterWell

Authorization to Release or Request Protected Health Information

PATIENT INFORMATION:		
Last Name:		**First Name:**
Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Date of Birth:**	

NAME OF PROVIDER OR HEALTHCARE FACILITY RELEASING INFORMATION:		
Provider:		
Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Fax:**	
From: / / **To:** / /		☐ All past and future Dates
Start Date	**End Date**	

NAME OF PROVIDER OR HEALTHCARE FACILITY REQUESTING INFORMATION [SEND TO]:		
Provider:		
Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Fax:**	

From: / / **To:** / / ☐ All past and future Dates

Start Date **End Date**

SIGNATURE REQUIRED:

I understand that by signing and submitting this form, I am authorizing the name of the clinic below to receive or release my complete heath records, including the following:

_____

Name of Clinic

My complete health records including:

☐ Mental Health ☐ HIV or AIDS ☐ Communicable diseases

☐ Treatment of alcohol/drug abuse

☐ Diagnosis, lab tests, prognosis, treatment, and billing for all condition

For the purposes of:

☐ Medical Treatment or consultation ☐ Billing or claims payment

Other purposes as I may direct: _____

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Patient Name:_____ **Date of Birth:**_____

I understand the following:

♦ This authorization is valid for the information already in existence and any information that may be generated while this authorization is effective.	♦ The revocation will **not** apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
♦ I have the right to see any information that is disclosed pursuant to this authorization for release and I may request to see this information during normal business hours.	♦ Authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization. ♦ I need not sign this form in order to assure treatment, payment or eligibility for services.
♦ I can revoke my authorization at any time and that the revocation will not apply to information that has already been released in response to this authorization.	♦ If the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential.

Unless otherwise revoked, this authorization shall expire **12 months** following the date of signature.

I acknowledge that I have read this form or it has been read to me and I understand its content.

Print Name: _____ Date: _____

Signature: _____ Date: _____

Name of Interpreter/Translator (if required) _____ Phone Number _____

OFFICE USE ONLY

Office Personnel (Print Name) _____ Date _____

Office Personnel Signature _____ Date _____

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Important!

At CenterWell Senior Primary Care, it is important you are treated fairly.

CenterWell Senior Primary Care (CenterWell) does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. CenterWell complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CenterWell, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-2188** or if you use a **TTY**, call **711**.

- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-2188 (TTY: 711)

CenterWell provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-2188 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어(Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت خدمات رایگان زبانی بصورت رایگان با شماره فوق تماس بگیرید. **Diné Bizaad**

ËNavajoħ: W0dah7 b44sh bee hani'7 bee wolta'7g77 bich'9' h0d77lnih 47 bee t'11 jiik'eh saad bee 1k1'1n7da'1wo'd66 nik1'adoowo[.

العربية (Arabic)

الرجاء االتصال بالرقم المبين أعاله للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220