Primary Care Partners
Affiliated with
Atlantic Health System

Authorization to Use or Disclosure PHI

Protected Health Information (PHI) Use and/or Disclosure

I do hereby consent to and authorize Primary Care Partners ________________________________ (Name of Care Center to disclose to the person(s) named, information from my medical records relating to my treatment, payment, and healthcare operations as I have indicated below. I Understand that this consent shall operate as a complete release of liability to Primary Care Partners, the Care Center and to its employees for the release of information as specified below.

____ (Name) ______________________________________ (Relationship)

____ (Name) ______________________________________ (Relationship)

____ (Name) _______________________________________ (Relationship)

This authorization permits Primary Care Partners, ______________________________________ (Name of Care Center) to use and/or share with the individuals noted above any part of my individual, identifiable health information, <u>with the exception of information related to:</u>

☐ **Alcohol & Drug Use** ☐ **Sexual Activity or Sexually Transmitted Disease** ☐ **Pregnancy** ☐ **Other______________**

I have the right to refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, Insurance Payment, or eligibility benefits. When my information is used or shared based on this authorization, the recipient may share it with others and my PHI may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the Care Center has acted upon the authorization. My written revocation must be submitted to the Primary Care Partners Care Center.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize Primary Care Partners to use or disclose my health information in the manner described above.

Patient Signature ____ Date of Birth ____________________________

Patient Printed Name ____ Witness ________________________________

Date: ______________________