Release of Information To Hive Mental Health and Wellness

This form provides a release of protected health information to Hive Mental Health and Wellness
If printing to sign, please fax back to 804-203-0806

* Indicates required question

1. Email *

2. Patient first name *

3. Patient last name *

4. Date of birth

Example: January 7, 2019

I whereby authorize the disclosure of my protected health information. Please list any other provider or entity (hospital, clinic, etc.) as well as listing any family members to whom you wish to share this information.

5. Entity/Provider name: *

6. Entity/Provider street address *

7. Entity/Provider city: *

8. Entity/Provider state: *

9. Entity/Provider zip code: *

10. Entity/Provider phone: *

11. Entity/Provider fax: *

12. What information would you like to disclose? *

Check all that apply.

- [ ] Disclose my complete health record including, but not limited to, diagnosis, lab test results, treatment, appointment information, prescriptions, and billing records for all conditions.
- [ ] Disclose my complete health records EXCEPT for the following information (chose all that apply):
- [ ] Mental health records, (communications made by me to a social worker or psychologist)
- [ ] Communicable diseases (HIV, AIDS, VD, TB, Hep B) as defined by statute MCLA 333.5131
- [ ] Alcohol/drug abuse treatment records protected under 42 Code of Fed Reg, Part 2
- [ ] Genetic information
- [ ] Other: _____

13. Please specify the purpose and need for such disclosure: *

Check all that apply.

- [ ] Continuity/Collaboration of Care
- [ ] At my request
- [ ] Other: _____

14. Duration of Authorization: *

Check all that apply.

- [ ] From and To Dates (insert dates below under other)
- [ ] All past, present and future periods
- [ ] The date of the signature on this form until the following event (insert event below under other)
- [ ] Duration of care at Hive Mental Health and Wellness
- [ ] Other: _____

15. Name of person completing this form if other than patient (write self if patient completing): *

_____

16. Relation to patient *

Mark only one oval.

- ◯ Self
- ◯ Other: _____

17. I understand, as set forth in the above-named practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer, except to the extent that the person or organization that is to make the disclosure has already taken action in reliance on my authorization. I understand the Practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. Further, if the practice will receive payment for obtaining this information, I understand I will be notified of the same. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. *

Mark only one oval.

- ◯ Yes, and I agree

18. Today's date: *

_____

Example: January 7, 2019

19. Patient signature (sign if printed, typed counts as signature if patient completes online) *

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