Authorization for Disclosure of Health Information

Section 1 I hereby authorize Comprehensive Care Services, Inc. to release/disclose the following information of:

Patient/Member First Name	Patient/Member Last Name	Patient Date of Birth (mm/dd/yyyy) / /
Member Address 1		
Member Address 2		
Member City	Member State	Member Zip Code
Member Identification Number	Telephone	

The records to be disclosed cover the following period(s):

From (mm/dd/yyyy)	To (mm/dd/yyyy)
From (mm/dd/yyyy)	To (mm/dd/yyyy)

Section 2 ☐ Check if this authorization is for psychotherapy notes.
If this authorization is for psychotherapy notes, you must **not** use it as an authorization for any other type of protected health information.

Section 3 Information to be disclosed (Please check only that which applies):
Designated Record Set: (Please check only that which applies)

☐ Enrollment Information ☐ Claims Information ☐ Payment Information

☐ Managed Care Information (Precertification, 2nd Opinions, Treatment Plans, Care Coordination, Case Management, etc.)

AND/OR

☐ Pharmaceutical information ☐ History of physical examination

☐ Explanation of Benefits ☐ Complete health record(s)

☐ Consultation reports ☐ Laboratory tests

☐ Discharge summary ☐ X-Ray Reports ☐ Progress Notes

☐ Other (please specify)

I understand that this will include information relating to (check if applicable):

☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)

☐ Mental health care ☐ Sexually transmitted disease

☐ Treatment for alcohol and/or drug abuse

☐ Other (please specify) _____

_____

Section 4 This information is to be disclosed to:

Organization or Provider

by Releaser for the purpose of

Section 5 I understand that I may revoke this authorization at any time by giving written notice of my revocation to Comprehensive Care Services, Inc. I understand that revocation of this authorization will affect not any action Releaser took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, Releaser may not use or disclose my health information for any reason except those described in Releaser's Notice of Privacy Policies and Practices. This authorization will end one year from the date this form is signed unless I indicate an earlier date or event here:

Expiration date (mm/dd/yyyy) or specific event

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that Releaser may condition my enrollment or eligibility for benefits on my signing of this authorization (other than for psychotherapy notes), before Releaser enrolls me, to allow Releaser to obtain protected health information from another covered entity to determine my eligibility or enrollment or Releaser's underwriting or risk rating.

I understand that Releaser may condition payment of a claim for specified benefits on my signing of this authorization (other than for psychotherapy notes), to allow other covered entities to disclose protected health information to Releaser that Releaser needs to determine payment of my claim.

Releaser, its subsidiaries, affiliates, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed (Patient/Member)	Date (mm/dd/yyyy)

Signature (Patient/Member)

(Personal Representative)	Date (mm/dd/yyyy)

(Include a description of such representative's authority to act for the patient)

Please mail the completed form to:

Comprehensive Care Services, Inc.
P.O. Box 64668
St. Paul, MN 55164

This form can also be faxed to (651) 662-1533