CARTI AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. I, _____, authorize CARTI to disclose certain protected health information to:

   Name/Facility: _____

   Address: _____

   Phone: _____ Fax: _____

2. Patient whose information is to be disclosed:

   Name: _____ Date of Birth: _____

   CARTI Location(s) Where Patient is Being Treated: _____

3. Specific information to be accessed or released:

   ____ Complete Medical Record, including records of other providers on file with CARTI, if any.
   ____ Information limited to the following dates of treatment: _____
   ____ History and Physical
   ____ Diagnosis
   ____ Laboratory Reports
   ____ Pathology Reports
   ____ Radiology Reports
   ____ X-rays, ultrasounds, and any other images, only if specifically requested by designated recipient
   ____ Billing Records
   ____ Other: _____

4. The purpose of this disclosure is:

   ____ Continuity of Care
   ____ Insurance
   ____ Legal Reasons
   ____ Personal Records
   ____ At the request of the patient
   ____ Other: _____

5. This authorization (check one):

   ____ Will not expire unless it is revoked in writing
   ____ Will expire when the following event or date occurs: _____

6. Preferred format:

   ____ Paper copies
   ____ CD-ROM

7. Method of delivery:

   ____ Pick-up at facility
   ____ Mail to address listed above
   ____ Mail to address/facility at: _____

8. I understand that if the records requested contain information on sexually transmitted disease, HIV, AIDS or related conditions, other communicable diseases, genetics, alcohol abuse, drug abuse, or psychiatric or psychological conditions (except psychotherapy notes), that this authorization includes that information.

9. I understand I have the right at any time to revoke this authorization in writing except to the extent that CARTI has already acted in reliance on it. I understand my written revocation must be submitted to CARTI and will become part of my medical record.

10. I realize that when the above information is disclosed, it may be re-disclosed by the recipient, and there is no guarantee that it will continue to be protected by the federal HIPAA Privacy Rule.

11. A photocopy of this authorization is as valid as the original.

12. I understand that CARTI will not condition treatment, payment for healthcare services, enrollment or eligibility for healthcare benefits on signing this authorization.

13. I release CARTI, its employees and physicians from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____ _____
Signature Date

_____
Patient Name (Printed)

_____
Name of Legal Representative*, if applicable (Printed)

**If signed by Legal Representative, please attach copy of power of attorney, court records, or other documents establishing legal authority to act for Patient (e.g., personal representative for estate).*

For HIM Office Use Only

Identification: ___ Driver's License:_____ ___ State ID:_____ ___ Military ID:_____

If signed by a Legal Representative, indicate authority and documentation submitted:
___ Death Certificate ___ Power of Attorney ___ Court Order ___ Letters of Guardianship ___ Other: _____

Processed by:_____ Date:_____ Mailed/Faxed/Given by:_____

Comments:_____

_____

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