Hopebridge Patient Paperwork

HIPAA Authorization– Release of Information Instructions

If you wish to have Hopebridge disclose your personal and health information to a third party acting on your behalf such as a physician, school, non-custodial parent, family member, legal representative or others, this **Release of Information Authorization Form** must be **completed and returned** for every person and / or organization that you wish to have your health information disclosed.

Without a signed **Release of Information Authorization Form**, Hopebridge will be unable to assist any third parties with inquiries including medical history, claims status, therapy progress, care coordination and other service purposes.

Obtaining or Requesting Authorization Forms

- All patients will receive a **Release of Information Authorization Form** in their initial Patient Paperwork packet.
- A blank copy of the **Release of Information Authorization Form** can be obtained at the Clinic or Care and Benefits Coordination Department upon request.

Completing the Authorization Forms:

- Please complete the enclosed **Release of Information Authorization Form** carefully in its entirety.
- If the **Release of Information Authorization Form** is not filled out completely, signed and dated, it may be returned and result in the information not being released until completed.
- Other than the patient's parent or custodial parent, legal guardian or authorized representative, every individual or organization must have a completed **Release of Information Authorization Form** on file to receive information.
- Authorizations will remain in effect for one year or until the date of discharge from services if earlier or if the authorization is revoked by you in writing (see item #9 on the **Release of Information Authorization Form**).

Submitting Completed Authorization Forms:

Provide completed **Release of Information Authorization Form** directly to the Clinic Manager.

NOTICE*:* If you send personal and health information to Hopebridge via email, please know that your message may be sent in an unencrypted email. An unencrypted email means there is a risk that the information in the email and any attachments could potentially be read by a third party when it is sent through the internet.

If you have questions, please contact the Care and Benefits Coordination Department Monday through Friday, between the hours of 8:00 AM and 6:00 PM EST at 1-855-324-0885.

Hopebridge Patient Paperwork

Release of Information Authorization Form

1. I, the undersigned, authorize Hopebridge to release protected health information (PHI) as indicated/described below. I understand and acknowledge that the requested information may contain information regarding the diagnosis and medical treatment concerning:
   Patient Name: _____
   Date of Birth:_____
   Address: _____
   City: _____State: _____ Zip:_____

2. Please check all program services/ therapies that apply for the information to be released:
   Applied Behavioral Analysis (ABA) _____
   Occupational Therapy _____
   Physical Therapy _____
   Speech Pathology Therapy _____
   Feeding/Swallowing Therapy _____

3. Please specify the range of treatment dates authorized for release:
   All Treatment Dates (check if applies): _____
   Specific Date Range Only: Start: _____ End: _____

4. Please check the type/amount of information to be used or disclosed:
   Diagnostic Report _____
   Evaluation Report _____
   Consultation Report _____
   Progress Notes _____
   All other personal and health information _____
   Claims and Billing Information _____
   Other (describe): _____

5. This information may be disclosed to, and used by the following individual or organization ("*authorized party*"):
   Individual/Organization: _____
   Address: _____
   City: _____ State: _____ Zip:_____
   Phone: _____ Fax: _____

6. This information is being disclosed for the following purposes (check all that apply):
   Collaboration of care _____
   Transition to other provider or school _____
   Obtaining insurance authorization _____
   Other (describe): _____

7. I give permission to leave a voice message for the *authorized party* described above: ❑ Yes ❑ No

8. If authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

9. I understand that I have a right to revoke this authorization at any time (or my legal representative) through written notice presented to the Clinic Manager and / or Care and Benefits Coordination Department. I understand that the revocation will not apply to information that has already been released in response to this authorization or to the extent that someone has already acted in reliance on this authorization. I understand that 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. Unless otherwise revoked, this authorization will shall be in force for either:
    a) one year
    b) until the date of discharge from program service (s) at Hopebridge
    c) a date no later than: _____

10. I understand that I have a right to one free copy of my personal and health records. Additional copies can be obtained for a fee; $20.00 for the first 1-10 pages, $0.50 per page for pages 11-50 and $0.25 per page for pages 51 and higher.

11. I understand that I may inspect or copy the information to be used or disclosed, as provided in HIPAA Privacy Rule 45 CFR 1647.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules after it is released. If I have questions about obtaining/disclosure of my health information, I can contact the Care and Benefits Coordination Department at 1-855-324-0885.

_____

Print Name

_____ _____

Signature of Legal Guardian **Date**

RE: Release of Information Authorization Form