Aspire Wellness

1738 Gilsinn Lane ● Fenton, MO 63026
Phone (636) 594-7883 ● Fax (636) 686-6979

AUTHORIZATION TO RELEASE INFORMATION

Name _____ Date of Birth _____

Address _____ Phone Number _____

I authorize_____ to disclose my Protected Health Information to

Name _____
Address _____
Phone _____

For the purpose of _____

I request that the following information be disclosed:

__ Dates of service from _____ to _____
__ Services related to _____
__ Other _____

This authorization shall expire on _____ or one (1) year from the date of signature, whichever occurs first.

- I understand that this authorization is voluntary and I am not required to sign it to receive healthcare services, payment, enrollment or eligibility for benefits.
- I understand that I may revoke this authorization at any time prior to its expiration date by submitting written notice of revocation to the releasing organization. I understand that my revocation will have no effect on any actions taken pursuant to this authorization prior to the revocation.
- I understand that the information disclosed pursuant to this authorization may be further disclosed by the recipient and may no longer be protected under HIPAA.

_____ _____
Signature Date

_____ _____
If Personal Representative, Printed Name Relationship to Individual

In addition to the authorization provisions above, I authorize the release and re-disclosure of all information, data, notes, records, reports, and all other documents to the Requestor, its consultants, experts, agents and/or other counsel relating to:

- ☐ SUBSTANCE ABUSE (ALCOHOL/DRUG)
- ☐ MENTAL HEALTH (INCLUDING PSYCHOLOGICAL TESTING)
- ☐ HIV-RELATED INFORMATION (INCLUDING AIDS TESTING)
- ☐ GENETIC INFORMATION

THIS FORM DOES NOT AUTHORIZE RE-DISCLOSURE OF MEDICAL INFORMATION BEYOND THE LIMITS OF THIS CONSENT. WHERE ALCOHOL/DRUG ABUSE INFORMATION HAS BEEN DISCLOSED THROUGH RECORDS THAT ARE PROTECTED BY FEDERAL LAW, OR MENTAL HEALTH RECORDS PROTECTED BY STATE LAW, FURTHER DISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PATIENT OR AS OTHERWISE PERMITTED BY SUCH LAW AND/OR REGULATIONS. A GENERAL AUTHORIZATION IS NOT SUFFICIENT FOR THESE PURPOSES.

_____ _____
Signature Date

_____ _____
If Personal Representative, Printed Name Relationship to Individual