



# PATIENT INFORMATION RELEASE

USE ONE RELEASE PER PERSON/FACILITY

I, \_\_\_\_\_, give permission to all staff at Help-Us Help-U, Inc to

Speak with: 1 \_\_\_\_\_

*(1st Relationship and Contact Number – Please Print)*

2 \_\_\_\_\_

*(2nd Relationship and Contact Number – Please Print)*

regarding all aspects of my care, including but not limited to, making and canceling appointments, billing and insurance matters, housing, and all issues relating to my medical and dental care. In the instance of death, the designee is given permission to request limited medical records.

All information hereby authorized by me to be obtained by Help-Us Help-U, Inc, Inc. will be held strictly confidential and cannot be released by the recipient without my written consent.

*I understand that this authorization will remain in effect until revoked by me in writing.*

**Notice to Patient:** By signing this form, you grant us consent to disclose your protected health care information to the individual(s) listed above. Our Notice of Privacy Practices provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information. You understand that the above information may be redisclosed by the recipient and may not be protected by federal privacy laws or regulations. Any information covered under 42 CFR part 2 will not be redisclosed. You understand that completing this authorization form is voluntary and that treatment will not be denied if you refuse to sign this form. You may request a list of protected health care information disclosures made on your behalf.

You have the right to **revoke** your authorization by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this authorization. You are entitled to a copy of this **authorization form** after you have signed it.

Date

Patient Signature

Date

Patient Printed Name

Date

Representative/Guardian Signature

Date

Representative/Guardian Printed Name and Relationship

### **Withdrawal of Consent**

Date consent revoked

Patient/Representative/Guardian Signature

Date

Witness Signature and Printed Name