AVIVA HEALTH

150 Kenneth Ford Drive, Roseburg, OR 97470 Phone: 541-672-9596 Fax: 844-870-1183

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION: Completion of this document authorizes the disclosure and/or use of health information. Please be sure to provide all information requested. Failure to do so may invalidate this authorization.

If we, the healthcare provider, are requesting this Authorization from you for our own use and disclosure, or to allow another healthcare provider, or health plan, to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2. The recipient of the health information released by this Authorization may re-disclose that information to another healthcare provider or health plan; health information re-disclosed by the recipient is not protected by this Authorization or the HIPAA rules or regulations.
3. You may inspect a copy of the protected health information to be used or disclosed;
4. You may refuse to sign this Authorization; and
5. We must provide you with a copy of the signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer.

Patient's Name: _____ Date of Birth: _____

Previous Names: _____ Social Security #: _____

Phone Number: _____

I request and authorize:

Name: **Aviva Health**

To release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

RECORDS WILL BE MAILED CERTIFIED TO THE RECIPIENT, IF NO FAX NUMBER IS INDICATED.

Purpose of Disclosure:

Purpose: _____

By initialing the spaces below, I specifically authorize the release of the following:

_____ **All Records** – sensitive protected information: HIV/AIDS, Mental Health, Genetic Testing, and Drug/Alcohol Use. If this area is not initialed below, we must read through documentation and redact any pertinent information. We will only redact documents back one year.

OR:

_____ Clinician Office Notes _____ Laboratory Reports

_____ Diagnostic Imaging Reports _____ Pathology Reports

_____ Other: _____ (be specific)

Consent is required for any disclosure of records to be sent regarding sensitive information below:

_____ **By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.**
By initialing here, I specifically consent to the disclosure of my mental health information.

_____ **By initialing here, I specifically consent to the disclosure of any and all STI/STD information.**

_____ **By initialing here, I specifically consent to the disclosure of my genetic testing information.**

_____

By initialing here, I specifically consent to the disclosure of my drug and alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

Patient Signature or Legal Guardian: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 12 MONTHS AFTER IT IS SIGNED