Cognitive Aging Research and Education Center

Patient ID: _____

Authorization for Release of Protected Health Information to Care Partners

I acknowledge that it is my right to restrict the Cognitive Aging Research and Education (CARE) Center's use and disclosure of my personal health information. I recognize that the information released to the person(s) of my authorization may be re-disclosed by those parties and may no longer be protected by federal privacy regulations.

I hereby authorize the Cognitive Aging Research and Education (CARE) Center to disclose and discuss my medical information with the following individual(s) (e.g., family members or other care partners; **NOTE**: there is a separate form for medical providers):

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The following protected health information may be released/discussed with the individual(s) listed above (please check **ONE** of the following boxes):

☐ Complete medical record (including lab and radiology reports)
☐ Abstract of medical record (provider-dictated reports & diagnostic reports) **ONLY**
☐ **ONLY** specific types of protected health information (specify here): _____

_____

This authorization for the release of protected health information shall remain in effect until the earlier of any of the following dates:

(a) The date I revoke this authorization in writing; **OR**
(b) Five (5) years from the date on which I signed this authorization

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that my/the patient's treatment at the CARE Center will not be affected if I refuse to sign this authorization.

I understand the information in my health record may include information relating to pregnancy, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health history/services/diagnosis/testing, and treatment for alcohol and drug abuse.

I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I also understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage.

NOTE: Please read **BOTH PAGES** of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient **OR** (ii) the patient is alive and you are legally authorized to make their healthcare decisions, including the release of medical records.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Patient Name (Printed) **Patient Date of Birth**

_____ _____

Signature of Patient (or Legal Representative) **Date**

_____ _____

Name of Legal Representative **Relationship to patient (if Legal Rep.)**