

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ MRN# _____

Patient Authorization to Release Information

I give authorization to the following person(s) to discuss my medical care, appointments, and billing account information with any staff member of AccelHealth. You may use the same person listed as your emergency contact.

Name of Person(s) Authorized	Relationship to Patient	Access to PHI (check all that apply)
		Full access; Scheduling only; Billing only; Behavioral Health; Medical; Dental
		Full access; Scheduling only; Billing only; Behavioral Health; Medical; Dental
		Full access; Scheduling only; Billing only; Behavioral Health; Medical; Dental
		Full access; Scheduling only; Billing only; Behavioral Health; Medical; Dental
		Full access; Scheduling only; Billing only; Behavioral Health; Medical; Dental
		Full access; Scheduling only; Billing only; Behavioral Health; Medical; Dental

I authorize this Release to be kept on file at the clinic and that it can be cancelled, revoked or have changes in authorized person(s) at any time by my written request.

Records and Confidentiality: In the case of medical, dental, mental/behavioral health services, counseling and/or case management, all communications become part of the clinical record. The clinical record may be viewed by the providers in the medical, dental and/or mental/behavioral health department for reasons including; consultation or transfer of clients due to vacation, illness, termination or death. This is kept confidential with the following exceptions:

- 1.) You provide us with a written release to share our information with someone else.
- 2.) Reporting abuse or neglect as required by law.
- 3.) We determine that you are a danger to yourself or others.
- 4.) We are ordered by a court to disclose information.

 Patient/Guardian Signature

 Date