Authorization to Disclose Health Information

avēsis

Member Information: (Individual whose information will be released)

Name: _____ Date of Birth: _____
(First, Middle, Last) (Month/Day/Year)

Address: _____
City State Zip Code

Telephone Number: _____
(including area code)

Medicaid or Member ID #: _____

I authorize the use or disclosure of personal and health information by Avēsis, as described below:

☐ Entire medical record in the possession of Avēsis.

☐ Claim information regarding treatment for the following condition or injury _____

_____ on or about _____

☐ Health information covering the period of time _____ to _____

☐ Other (Please specify and include dates) _____

_____

This information may be disclosed to, and used by, the following individuals or organizations:

Name: _____ Relationship _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ Relationship _____

Address: _____

City: _____ State: _____ Zip: _____

This information is being disclosed for the following purpose(s):

_____

_____

Expiration date for this authorization (optional-will be 24 months unless specified): _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Avēsis at the address below. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that if I have provided this authorization as a condition of obtaining insurance coverage, a revocation will not apply to Avēsis when the law provides it with the right to contest a claim under my group plan. Unless otherwise revoked, this authorization will expire within twenty-four (24) months of the signature date or the expiration date requested above, whichever is sooner.

I understand that I do not have to sign this authorization and that Avēsis may not condition treatment or payment on whether I sign this authorization.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the member (e.g., Health Care Power of Attorney).

Please send this form to:

Avēsis, LLC.
Privacy Office
1295 W. Washington Street, Suite 212
Tempe, AZ 85281
Email to: privacyoffice@Avesis.com