Authorization to Release Healthcare Information to Coraggio, LLC, Mobile Health Team (D/B/A)

Patient's Name: _____ **Date of Birth**: _____

I request and authorize:

Name: _____ ("**Entity**") Fax #_____

Address: _____Phone #_____

City: _____ State: _____ Zip Code: _____

To release healthcare information of the patient named above to:

Ann Liebeskind, MD c/o Mobile Health Team, Fax to (844) 885-9574
Or Mail to Ann Liebeskind, MD, PO Box 1050, Neenah, Wisconsin 54957

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates _____

_____

This authorization also applies to: (check any that are applicable): _____ mental health records

_____ developmental disability records _____ alcohol or drug abuse records _____ HIV test results

The purpose or need for the disclosure: coordinate care or Other: _____

(e.g., further medical care, insurance benefits, at the request of the patient, etc.)

This authorization is valid until: _____ (enter date or event) or One year from today.

Your Rights with Respect to this Authorization: You have a right to inspect or obtain a copy of the information authorized to be disclosed by Entity under this authorization form. Upon signing this authorization, you will be provided with a copy of the signed authorization form. You are under no obligation to sign this form. Coraggio, LLC, D/B/A Mobile Health Team and Entity may not condition treatment, payment or enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization. You may withdraw this authorization at any time by providing a written statement of withdrawal to Entity at the address for Entity written above. Your withdrawal will not be effective until received by Entity and will not be effective with respect to any uses or disclosures of your information prior to receipt of your withdrawal statement.

Re-disclosure Notice: The information used or disclosed based on this authorization may be subject to re-disclosure by the Recipient and no longer protected by federal health care privacy law.

I have had an opportunity to review this form and understand it. This form accurately reflects my wishes.

Signature of Patient/Legal Representative: _____ **Date Signed**: _____

Printed Name of Legal Representative (if patient did not sign): _____

Relationship of Person Signing to Patient (if patient did not sign):

_____ Legal Guardian _____ Parent of Minor Other: _____