Release of Information From Coraggio LLC, D/B/A Mobile Health Team to Another Entity

Patient's Name: ___________________________________ **Date of Birth**: ______________________________

I request and authorize: Coraggio LLC D/B/A Mobile Health Team

To release healthcare information of the patient named above to:

Name: ____ ("**Entity**") Fax #______________________

Address: ____Phone #__________________

City: ____ State: ____________ Zip Code: _________

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 Coraggio, LLC D/B/A Mobile Health Team (MHT) 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 (MHT) may not condition treatment, payment or enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization, except with respect to: (a) research-related treatment; or (b) the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party. You may withdraw this authorization at any time by providing a written statement of withdrawal to Coraggio, LLC (MHT) at the address above. Your withdrawal will not be effective until received by Coraggio, LLC (MHT) and will not be effective with respect to any uses or disclosures of your information prior to receipt of your withdrawal statement. If Coraggio, LLC (MHT) will use this authorization for marketing purposes, Coraggio, LLC (MHT) will inform you if it receives any direct or indirect payment in connection with the use or disclosure of your information for such marketing purposes prior to you signing this authorization form.

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: __________________________________