Medical Records Release Form

Alius Health, LLC, uses this form to get your permission to use and/or disclose your protected health information (PHI) to you or your authorized representative. This authorization does not allow your authorized representative to make any of your treatment decisions or direct care decisions.

Use this form to request authorization for the release of PHI, including patient profile or records, to your authorized representative(s) named in Section 2 below. When filling out this form, please provide your most current information.

Section 1: Claimant Information

Claimant Name			
	First	**Middle**	**Last**

Claim Number		Date of Injury	
Claimant Street Address			
City, State, Zip Code			
Claimant Telephone		Claimant Email	
Claimant Date of Birth			

Section 2: Requesting Entity or Healthcare Professional

Company/Organization Name			
Name of person requesting the record			
Address			
Phone		Fax	

Section 3: Identity Authentication

Please mark the selections below that correctly identify you / your organization's interest in this claimant's health record.

☐ I am the injured claimant/ patient.

☐ I am an authorized representative of the patient. I have been granted legal permission to access these records in accordance with the worker's compensation State Guidelines for HIPAA disclosure in the state of jurisdiction or I possess state authorized P. O.A. for the claimant.

☐ I represent the claimant in legal proceedings, or am an affiliate of a law practice that is legally representing the claimant. *Proceed to Section 4

☐ I am an employee or legally authorized representative of a third party affiliated healthcare organization.

Section 4: Description of Information to Disclose

I authorize the following PHI to be released from my medical records

From _____ **To** _____

Date of Service **Date of Service**

Please check all that apply:

☐ Prescription history
☐ Claim notes
☐ Claim activity log
☐ Invoices
☐ Claim documents
☐ Other (please specify)

_____

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

State and federal law protects the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate).

Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No Dates: _____

HIV Testing and Results ☐ Yes ☐ No Dates: _____

Mental Health ☐ Yes ☐ No Dates: _____

Psychotherapy Records ☐ Yes ☐ No Dates: _____

Section 5: Purpose of Disclosure

If you are not the patient, please disclose the purpose for requesting the patient's health record below:

Section 6: Expiration and Revocation

I understand that I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Alius Health, LLC at the following address: PO Box 71 Worthington, Ohio 43085. Revocation will not apply to information that has already been disclosed in response to this authorization. I also understand that revocation may result in a suspension or delay of my worker's compensation claim.

Unless otherwise revoked, this authorization will expire on _____

Enter Date Above

If I do not specify an expiration date, the authorization will expire twelve (12) months from the date of signature noted below.

Patient Signature	

Section 7: Legal Representative Designation

If this authorization is signed on the patient's behalf by his/her legal representative, please attach documentation evidencing legal representative's designation and complete the following:

Legal Representative's Name		Phone Number
Mailing Address		
City	State	Zip
Relationship to Patient		

Section 8: Delivery Method Selection

Please select how you would like to receive the requested record. To ensure delivery, please complete the corresponding fields to your selection.

☐ Fax	Attention	
	Fax Number	
☐ Email	Email Address	
☐ Postal mail	Street Address	
	City, State, Zip Code	
Date Needed by: (Required)		

(Please note after your request is received please allow 5-10 business days for Alius Health LLC to gather all documents.)

Section 9: Mail, Email, or Fax the completed form to:

Alius Health, LLC
PO Box 71
Worthington, Ohio 43085

(P)740-661-4463
(F)740-305-0596
pharmacysupport@aliushealth.com