Coram®

CVS specialty® infusion services

Authorization for Release of Protected Health Information (PHI)

Patient Name (Records to be released): _____

Street: _____

City, State, ZIP code: _____ Date of Birth: _____

1. **Records** to be disclosed:
   ☐ Complete medical history ☐ Lab reports ☐ Itemized billing
2. **Sensitive Records** to be disclosed *(must select at least one option)*:
   ☐ Sexually Transmitted Disease/Infections lab reports
   ☐ Behavioral Health ☐ Request excludes sensitive records
3. **Dates of Service** to be disclosed:
   ☐ ALL Dates of Service ☐ Specific Dates of Service: _____
4. My Records may be disclosed **to the following person or company:**
   Person or Company Name: _____
   Mailing Address/Email Address: _____
5. I authorize Coram to disclose my Records **for the purpose of:**
   ☐ At the request of Patient or Patient's Personal Representative (no specific purpose)
   ☐ Specific Purpose: _____
6. This Authorization **will expire 6 months** from the date I sign it as shown below unless I enter a different expiration date here: ____/____/____
7. **By signing below, I understand and agree that:**
   - My Records may include sensitive information related to the treatment of mental health conditions, alcohol or substance abuse, sexually transmitted diseases like HIV/AIDS or other communicable and non-communicable diseases, and genetic marker information.
   - I may revoke this authorization at any time by writing to Coram at the address or email listed at the bottom of this form, except to the extent that Coram has acted in reliance on this authorization.
   - Signing this authorization is voluntary and that this authorization will not affect my ability to obtain treatment, payment for treatment or enrollment or eligibility for benefits from Coram. A photocopy or facsimile of this signed Authorization is as valid as the original and will be accepted.
   - Whoever gets my records may not be required to comply with applicable privacy regulations and may share it with others. That means federal or state privacy laws may no longer protect the information in my records.
   - I can mail the completed form to Coram at the address listed below; or I can fax the completed form to **1-951-256-4598**. I can also email it to **DL-ROI@coramHC.com**, but I understand that communications sent by email are not secure unless they are sent using technology that encrypts the email. There is a possibility that information included in an unencrypted email can be intercepted and read by other parties.
   - I have the right to receive a copy of this Authorization.

_____ _____

Signature of Patient/Personal Representative* **Date**

**If signed by someone other than the patient, please print your full name, explain your authority to act on behalf of this patient, and provide us paperwork evidencing this authority (i.e,. Power of Attorney or Guardianship form):*

Coram
Attention ROI
1471 Business Center Dr., Suite 500
Mount Prospect, Illinois 60056

Fax: **1-951-256-4598**
Email: **DL-ROI@coramHC.com**

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