Please return this completed form to your provider along with a copy of the form that needs to be completed.

Atrius Health
Part of Optum®

Authorization for Release of Protected Health Insurance To A Third-Party (e.g., FMLA, Disability & Other Forms)

PATIENT INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________
(Please Print)

Address: ______________________________ Telephone No.______________
Street City State Zip

PERMISSION TO SHARE & RECIPIENT INFORMATION - I hereby give permission for Atrius Health to share my protected health information, through completion of a form I have provided, to the following recipient:

Recipient:

____
(Please Print)

Address: ______________________________ Telephone No.______________
Street City State Zip

DELIVERY INFORMATION

Please check only one:

☐ Secure email: ______________________________ ☐ Mail via USPS to the address noted above
(Please Print Clearly)

☐ Fax to: ______________________ Attention Of: ______________________ ☐ Via MyHealth
(Fax Number)

PURPOSE OF FORM

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ School ☐ Disability ☐ FMLA ☐ Other (specify):______________

INFORMATION TO BE RELEASED

Form(s) To Be Completed: ______________________________

RELEASE OF INFORMATION REQUIRING SPECIFIC CONSENT

The following categories of information may be included in your medical record and ***WILL NOT*** be released unless you indicate your specific authorization by **INITIALING** each appropriate category.

Category	Initials
Abortion	
Alcohol/Drug Abuse	
Behavioral Health	
Domestic Violence	

Category	Initials
Genetic Testing	
HIV/AIDS Results/Treatment	
Rape/Sexual Assault	
Sexually Transmitted Diseases	

PLEASE CONFIRM THAT YOU HAVE INITIALED ALL CATEGORIES OF INFORMATION THAT YOU WOULD LIKE RELEASED

REVIEW AND SIGNATURE

I understand that I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at Atrius Health unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required. I may revoke this authorization at any time by submitting a written notice of revocation to Atrius Health at the address listed above. The revocation will be effective upon Atrius Health's receipt of my written notice, except that it will not have any effect on any action already taken by Atrius Health in reliance on this authorization. Once Atrius Health has disclosed my health information to the recipient, Atrius Health cannot guarantee that the recipient will not redisclose my health information to a third party. This authorization will automatically expire 90 days from the date set forth below unless otherwise specified: ______________

______________________________ ______________________________
Signature of Patient or Legal Representative **Date**

______________________________ ______________________________
Printed Name of Patient or Legal Representative **Relationship to Patient –** ***Proof of legal authority may be required***

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Internal use only:
Date Sent: ______________ **Printed Name of Atrius Staff:**______________________**DEPT:**______________