CLEARSKY CARE CONNECTIONS, LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Soc. Sec. #:** _____

I (PATIENT) authorize _____ **ClearSky Care Connection, LLC** and its related partners, associates and employees to disclose protected health information in any form (including oral, written and electronic) from _____ **(Insert Date)** to the present, to _____ **(Insert Name)** and agents, consultants and other counsel retained by _____ **(Insert Name)**. I authorize the release of the following protected health information, as defined in 45 C.F.R. §160.103:

INFORMATION REQUESTED:

_____

_____

_____

The purpose of this release is to _____ **(Insert Description)**. This authorization is effective until _____ **(Insert Date or Description)**. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider to which this authorization is directed. I understand this authorization is strictly voluntary and that the health care provider to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information may no longer be protected by federal privacy laws. Any facsimile, copy or photocopy of the authorization authorizes release the records requested herein.

Signature of Patient _____ **Date** _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW: In addition to the authorization and other provisions contained above which are hereby incorporated by reference, I (PATIENT) authorize: (i) the release of the health information indicated below to _____ **(Insert Name)**; and (ii) the re-disclosure of such health information by _____ **(Insert Name)** to its agents, consultants and other counsel.

☐ 1. Alcohol/Drug Abuse Information ☐ 2. Mental Health/ Psychological Testing Information ☐ 3. HIV-Related/AIDS Testing-Related Information

This form does not authorize re-disclosure of health information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by such law or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5000 in the case of each subsequent offense. Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175); Comprehensive Alcohol Abuse Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

Signature of Patient _____ **Date** _____