Authorization to Release Medical Information

** Indicates Required Field*

Patient Information:

*Name (Last, First): _____ *Date of Birth: ____/____/_____

*Phone Number: _____ *Email: _____

*Street Address: _____ *City: _____

*State: _____ *Zip: _____

***Medical Information to be Released**
(please check all that apply)**:**

- ☐ Patient Medical Chart (Visit Summary)
- ☐ Diagnostic Laboratory Testing/ Imaging Results (Other than those available in-app)
- ☐ Behavioral Health Therapy Notes
- ☐ Other:_____

***Purpose of Release:**

- ☐ Personal Use
- ☐ Insurance Use
- ☐ Legal Use
- ☐ Other:_____

Date Range of Medical Information to be released: from _____ to _____
If no dates are specified, the last 30 days of records will be released.

Deliver Medical Information to:

*Name/Organization: _____ Phone Number: _____

Fax Number: _____ *Email Address: _____

Street Address: _____ City: _____

State: _____ Zip: _____

***Format of Medical Information Requested via:**
Please note: If no option is chosen, Medical Information will be provided to the listed recipient electronically via Zendesk, a secure email messaging platform, with access instructions.

- ☐ Secure Email via Zendesk: _____@_____._____
- ☐ Fax to number listed above
- ☐ USPS Mail to address listed above
- ☐ Other (please specify):_____

Signature Required on Page 2

Required Notices:

- I authorize the release of Medical Information related to the patient listed on Page 1.
- The Medical Information released may include information relating to sexually transmitted infections, including but not limited to **HIV/AIDS, and psychiatric, behavioral or mental health information, treatment for Substance Use Disorders, and genetic information. My signature below means that I consent to release this information.**
- If the person or entity receiving the Medical Information is not a health care provider or health plan covered under federal privacy regulations, my Medical Information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- Treatment or payment for services rendered cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
- I have a right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to tc.support@transcarent.com or by fax to 855-342-9714. If I revoke this authorization, the revocation will not have any effect on actions taken by 98point6 prior to receiving my revocation. I understand that revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
- I understand that state law may permit 98point6 to charge fees for providing copies of my Medical Information.
- Unless revoked, this Authorization will automatically expire once 98point6 has released my Medical Information as requested in this Authorization. my Medical Information as requested in this Authorization.

Submission Instructions

To submit this Authorization, please complete and sign this form and provide it along with a copy of your government-issued identification (e.g., driver's license or passport) to tc.support@transcarent.com or by fax to 855-342-9714.

My Authorization: *My signature below indicates that I have read this form in its entirety and consent to the release of Medical Information as described.*

_____	_____	_____
*Signature of Patient or Legal Representative	*Relationship to Patient	*Date

**If you are the legally authorized representative of the patient, describe the scope of your authority and attach necessary proof.*

☐ *Durable Power of Attorney for Health Care*
☐ *Legally Authorized Representative*
☐ *Personal Representative of the Estate*
☐ *Other (specify and attach proof)*: _____