Authorization for Release of Protected Health Information (PHI)

My health record is private and is known under the law as "Protected Health Information" (PHI). By completing and signing this form, I, or my legal representative, agree to allow AllCare to share my PHI with the people listed below. By AllCare, I also mean the company's subsidiaries, affiliates, employees, agents and subcontractors. PLEASE COMPLETE ALL SECTIONS.

Please sign and return this completed form to:
AllCare IPA
Attn: Operations Auditor
3320 Tully Road
Modesto CA 95350

Or you can fax it to: 209-338-5678

I. Patient Information

Last name: First Name: Middle Initial:

My Member Number: My Birth Date (MMDDYYYY):

Street Address: My City, state, Zip

II. Individual to Receive the Information

Name:

Address: City, state and Zip Code

Relationship to Patient: Phone:

Name:

Address: City, state and Zip Code

Relationship to Patient: Phone:

III. Authorization Expiration Date for Release of Verbal Information

Unless otherwise revoked by the patient, this authorization for release of health care information to the above-named individual will expire on the date specified below or 12 months from the date signed in section V. whichever occurs first.

My authorization is valid from:

MM/DD/YYYY TO MM/DD/YYYY

VI. Authorization Information

I understand the following:

1. I authorize the disclosure of my individually identifiable protected health information as described above for the purposed listed. I understand this authorization is voluntary.
2. I have the right to revoke this authorization. To do so I understand I can submit my request in writing to AllCare IPA. The authorization will stop further release of my protected health information on the date my valid revocation request is received by AllCare IPA.
3. I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign this authorization.
4. Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI.
5. AllCare will not release my PHI to the individual(s) named in Section II unless I sign this form.
6. My eligibility for benefits and services won't change if I do not sign this form.

V. Patient Signature

Name: (Print)

Signature: Date:

If no expiration date is specified in section III, this authorization will expire 12 months from this date.
If patient is a minor, this authorization will expire on their 18th birthday.