The privacy of the patient's protected health information is very important to Altru Health System and its affiliates. The patient has the authority to control access to and disclosure of protected health information except for those disclosures that are allowed without patient authorization (as listed in the Notice of Privacy Practices). This form does not give you proxy access, that will need to be requested using the proxy request form or completed via MyChart.

Clinical information (i.e. test results, scheduled appointment information, clinical findings, and decisions) only.   Financial/billing information only   Both clinical and financial information   I do not want to authorize any specific contacts for clinical, financial, or billing information.   Can be discussed or shared with the following person(s):   Facility/Individual Name:	In filling out this form, I hereby request that:	
□ Both clinical and financial information □ I do not want to authorize any specific contacts for clinical, financial, or billing information.  Can be discussed or shared with the following person(s):  Facility/Individual Name:  Address: □ Phone Number: □ This authorization to disclose information to the designated individuals also includes the indicated sensitive records:  (please initial)  Psychotherapy Notes □ Psychiatry Notes □ HIV or AIDS □ Chemical Dependency □ Chemical Dependency □ This authorization is not limited to a certain time period or visit date. □ Limited authorization for the following time period or visit date(s): □ This authorization shall be in effect for 12 months following the date of signature.  I understand that this authorization will remain in effect until such time that I revoke it in writing to Altru Health System Health Information Management Manager or designee.  Patient Name: □ Patient/Patient Representative Signature: □ Print Name: □ Print Name: □ Print Name: □ Patient Name: □ Patient Patient Representative Signature: □ Print Name:		tment information, clinical findings, and
Can be discussed or shared with the following person(s):  Facility/Individual Name: Address: Phone Number:    My authorization is not limited to a certain time period or visit date.   Limited authorization for the following time period or visit date(s):   This authorization shall be in effect for 12 months following the date of signature.  I understand that this authorization will remain in effect until such time that I revoke it in writing to Altru Health System Health Information Management Manager or designee.  Patient Name: Patient Date of Birth: Patient/Patient Representative Signature: Print Name:	☐ Financial/billing information only	
Can be discussed or shared with the following person(s):  Facility/Individual Name:	☐ Both clinical and financial information	
Facility/Individual Name:	$\hfill \square$ I do not want to authorize any specific contacts for clini	cal, financial, or billing information.
Address:	Can be discussed or shared with the following person	(s):
Address:	Facility/Individual Name:	
Phone Number:		information to the designated individuals also includes the
Facility/Individual Name:	Phone Number:	
Phone Number:	Facility/Individual Name:	indicated sensitive records:
Phone Number:	Address:	(please initial)
Facility/Individual Name:		Psychotherapy Notes
Address:		Psychiatry Notes
Phone Number: Chemical Dependency My authorization is not limited to a certain time period or visit date.  Limited authorization for the following time period or visit date(s): This authorization shall be in effect for 12 months following the date of signature.  I understand that this authorization will remain in effect until such time that I revoke it in writing to Altru Health System Health Information Management Manager or designee.  Patient Name: Patient/Patient Representative Signature: Print Name:		HIV or AIDS
Limited authorization for the following time period or visit date(s):  This authorization shall be in effect for 12 months following the date of signature.  I understand that this authorization will remain in effect until such time that I revoke it in writing to Altru Health System Health Information Management Manager or designee.  Patient Name:  Patient/Patient Representative Signature:  Print Name:		Chemical Dependency
□ This authorization shall be in effect for 12 months following the date of signature.  I understand that this authorization will remain in effect until such time that I revoke it in writing to Altru Health System Health Information Management Manager or designee.  Patient Name:  Patient/Patient Representative Signature:  Print Name:	☐ My authorization is not limited to a certain time period	d or visit date.
I understand that this authorization will remain in effect until such time that I revoke it in writing to Altru Health System Health Information Management Manager or designee.  Patient Name:  Patient/Patient Representative Signature:  Print Name:	$\Box$ Limited authorization for the following time period or $v$	visit date(s):
writing to Altru Health System Health Information Management Manager or designee.  Patient Name:  Patient Date of Birth:  Patient/Patient Representative Signature:  Print Name:	☐ This authorization shall be in effect for 12 months foll	owing the date of signature.
Patient Date of Birth:  Patient/Patient Representative Signature:  Print Name:		
Patient/Patient Representative Signature:	Patient Name:	
Print Name:	Patient Date of Birth:	
	Patient/Patient Representative Signature:	
	Print Name:	

AUTHORIZATION TO DISCLOSE CLINICAL/FINANCIAL INFORMATION





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