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 proxyaccess and does not allow for release of medical records.

In filling out this form, I hereby request that:

- ☐ Clinical information (i.e., test results, scheduled appointment information, clinical findings, and care decisions) only. (Verbal Discussion Only)
- ☐ Financial/billing information only
- ☐ Both clinical and financial information

Can be discussed or shared with the following person(s):

Facility/Individual Name: _____

Address: _____

Phone Number: _____

Facility/Individual Name: _____

Address: _____

Phone Number: _____

Facility/Individual Name: _____

Address: _____

Phone Number: _____

This authorization to disclose information to the designated individuals also includes the indicated sensitive records:

(Please Initial)

Mental Health _____

HIV or AIDS _____

Chemical Dependency _____

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: _____

Date: _____