Release of Information From Coraggio LLC, D/B/A Mobile Health Team to Another Entity

Patient's Name _____ **Date of Birth**: _____

I request and authorize: Coraggio LLC D/B/A Mobile Health Team

To release healthcare information of the patient named above to:

Name: _____ ("**Recipient**")

Address: _____ Phone _____

City: _____ State: _____ Zip Code: _____ Fax _____

This request and authorization applies to:

☐ Specific Healthcare information (List type of info and for what dates/years) _____

_____

☐ All visit notes and labs for dates _____

This authorization also applies to: (check any that are applicable): ____ mental health records

____ developmental disability records ____ alcohol or drug abuse records ____ HIV test results

The purpose or need for the disclosure: To coordinate care

(e.g., further medical care, coordinate care, insurance benefits, at the request of the patient, etc.)

This authorization is valid until: One year from today.

Your Rights with Respect to this Authorization: You have a right to inspect or obtain a copy of the information authorized to be disclosed by Coraggio, LLC D/B/A Mobile Health Team (MHT) under this authorization form. Upon signing this authorization, you will be provided with a copy of the signed authorization form. You are under no obligation to sign this form. Coraggio, LLC (MHT) may not condition treatment, payment or enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization, except with respect to: (a) research-related treatment; or (b) the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party. You may withdraw this authorization at any time by providing a written statement of withdrawal to Coraggio, LLC (MHT) at the address above. Your withdrawal will not be effective until received by Coraggio, LLC (MHT) and will not be effective with respect to any uses or disclosures of your information prior to receipt of your withdrawal statement. If Coraggio, LLC (MHT) will use this authorization for marketing purposes, Coraggio, LLC (MHT) will inform you if it receives any direct or indirect payment in connection with the use or disclosure of your information for such marketing purposes prior to you signing this authorization form.

Re-disclosure Notice: The information used or disclosed based on this authorization may be subject to re-disclosure by the Recipient and no longer protected by federal health care privacy law.

I have had an opportunity to review this form and understand it. This form accurately reflects my wishes.

Signature of Patient/Legal Representative: _____ **Date Signed**:_____