WellPower™

AUTHORIZATION FOR THE ACCESS, USE, OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete all sections of this Authorization to Release Protected Health Information (PHI) form. Incomplete forms cannot be accepted and may delay the processing of your request. Be sure to provide accurate and up-to-date information, including your contact details, the specific records you wish to release, and the purpose of the disclosure.

If you're unsure about any section, we're here to help, so please reach out to the Health Information Systems Management team (HISM@WellPower.org) with any questions.

Section A: This section must be completed for all authorizations

Patient Last Name: _____	**Patient First Name:** _____	**Patient Date of Birth:** _____
Phone: _____	**Email:** _____	
Address: _____		
City: _____	**State:** _____	**Zip:** _____
Purpose of Disclosure: _____		

I hereby authorize WellPower to (please check at least one):

☐ **Exchange with**
(e.g., provider-to-provider)

☐ **Release to**
(e.g., a family member or attorney)

☐ **Obtain from**
(e.g., request records from another provider)

Recipient Name: _____	**Relationship to Patient:** _____	
Phone: _____	**Email:** _____	
Address: _____		
City: _____	**State:** _____	**Zip:** _____

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I hereby authorize the use or disclosure of the following health information:

☐ **Complete health record**

Records related to the following will not be included unless checked:

☐ Substance use disorder (SUD) treatment

☐ STD/HIV/AIDS

☐ Sexual assault reports or testing

☐ Genetic testing

☐ **ONLY the following health records (check all that apply):**

☐ Progress notes

☐ Treatment plans

☐ Labs/test results/orders

☐ Discharge summaries

☐ Medications

☐ Billing records

☐ Service date(s)

☐ Assessment(s)

☐ Other: _____

Date(s): _____

Section B: The manner in which you would like records delivered

☐ **Encrypted email**

Recipient's email address: _____

☐ **Unencrypted email**

Recipient's email address: _____

☐ **Fax**

Recipient's fax number: _____

☐ **Encrypted flash drive to the recipient's address listed above**

☐ **Encrypted CD-ROM to the recipient's address listed above**

☐ **Paper mail to the recipient's address listed above**

☐ **Records to be picked up in person at 4141 E Dickenson Pl, Denver, CO 80222**

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Section C: Expiration and Revocation

Please select one of the following expiration events:

☐ One (1) year from the date on which I, or my legal representative, signs this Authorization.

☐ Upon the happening of the following event (e.g., "Upon release of the above records"):

_____

I understand that:

1. I may revoke this Authorization at any time by providing written revocation to WellPower.
2. I understand that I may revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization.
3. Signing this Authorization is voluntary.
4. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this Authorization.
5. The information disclosed pursuant to this Authorization may be subject to re-disclosure, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you, by the recipient and no longer be protected by HIPAA upon its release to the recipient.
6. I have the right to inspect or copy the health information to be used or disclosed pursuant to this Authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Name (printed): _____

Patient Signature: _____ **Date:** _____

Representative/Guardian Name (printed): _____

Representative/Guardian Signature: _____ **Date:** _____

Relationship to patient (e.g., parent/legal guardian, power of attorney, surrogate decision-maker, executor, etc.)**:** _____