Workit Health

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

I voluntarily allow Workit Health to:

- [x] Release my Health Information
- [ ] Receive my Health Information

Patient Name

_____

Date of Birth

_____

Phone

_____

Active email address

_____

Address

_____

_____

3300 Washtenaw Ave., STE 280, Ann Arbor MI 48104 | **PHONE**:(855) 659-7734 **FAX**:(855) 716-4494 | medicalrecords@workithealth.com

Workit Health

SECTION 1: What information am I agreeing to share?

By signing below, I hereby authorize my Workit Health Clinic or agent, to use or disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. Such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and information from other providers that is contained in the information maintained by my Workit Health Clinic.

Use and Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

Disclosure of my Health Information is limited to:

- ☑ Psychotherapy notes
- ☑ Substance Use Disorder Evaluation, treatment, referral
- ☑ Sexually transmitted diseases
- ☑ HIV/AIDS-related treatment
- ☑ Mental health records (other than psychotherapy notes)
- ☑ Diagnosis/medication history/medication dosages
- ☑ Drug Screening Results
- ☑ Bloodwork/Lab work Results
- ☑ Physical Exam Results
- ☑ Verification of Treatment
- ☑ Dates of treatment attendance and treatment plans
- ☑ Progress notes and content of Workit Health courses
- ☑ Discharge summaries
- ☑ Any information needed to confirm the validity of my prescriptions and for submission for payment for the prescription

Workit Health

Date range to allow:

- [ ] last appointment and prescription only
- [ ] previous 30 days
- [ ] previous 90 days
- [ ] previous 6 months
- [ ] previous 1 year
- [x] full duration of treatment
- [ ] Other

SECTION 2: Purpose of disclosure

- [ ] Care coordination or treatment
- [ ] Ordering lab/drug tests
- [ ] Requesting External Physical Exam and or Lab Results
- [ ] To allow Workit Health to access external Information
- [x] Legal matter
- [ ] Personal
- [ ] Emergency Contact
- [ ] Assuring a pharmacy of the validity of any prescription and/or for payment purposes
- [ ] Payment purposes in general
- [ ] Other (please specify)

SECTION 3: Who do I want to share or disclose my information with?

- [ ] To the Patient at the above address
- [x] To another person or organization

Workit Health

Authorized Personel Name

Legal-Ease Digital Imaging LLC Pat Clifford

Address:

2496 Meadowcroft Dr Burton, MI 48519

Phone:

855-543-4003

Email:

pat.legalease@gmail.com

Fax:

810-547-4030

SECTION 4: Miscellaneous

If I fail to specify an expiration date or condition, this authorization is valid for the period of time lasting until I am discharged from my Workit Health Clinic or for up to one (1) year from the signature date, whichever is earlier. This authorization is subject to revocation at any time except to the extent my Workit Health Clinic who is to make the disclosure has already acted in reliance on it. Any revocation will be presented in writing to my Workit Health Clinic. My Workit Health Clinic will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization.I understand that I am explicitly authorizing both the disclosure of my Workit Health Clinic records and the re-disclosure of the other providers records. This authorization provides for a release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. 42 CFR Part 2 (“Part 2”) prohibits unauthorized disclosure of any Part 2 records. No information

disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.

SECTION 5: Signature

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release my Workit Health Clinic, its affiliates and its agent and representatives, from all legal liabilities that may result from the release of this information according to this request.

X

_____

Signature Date