American Health Network

215 Patient/Guardian Authorization to Disclose Protected Health Information to Others

Patient Name: _____ DOB: _____Today's Date: _____

Primary Care Provider & Location:_____

To the patient: American Health Network will attempt to follow your instructions to the extent the healthcare provider believes such disclosure will not interfere with your treatment. This form will be used at all AHN locations. Please note that AHN does not need specific authorization to disclose information for treatment, operations or payment purposes consistent with its Notice of Privacy Practices.

Authorization by: ☐ Patient ☐ Legal Guardian (name): _____

American Health Network may disclose all of my Protected Health Information* (including that about alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or information related to **psychiatric treatment or counseling, and related to communicable disease, unless I limit below) to**:

	Name	Relationship	Contact info (phone/address)	NextMD Access Y/N
1				
2				
3				

*** Limitation - The following Information may NOT be disclosed to any of the above**:

_____

_____

_____

Duration/Expiration: ONLY the most recent signed DISCLOSURE AUTHORIZATION will be honored. This Authorization will stay in effect during my treatment at AHN unless it is revoked/revised by me in writing. I agree that AHN is not responsible for information that might be re-disclosed by those persons who I have authorized to receive information.

Patient/Guardian Signature:_____

Date: _____

Provide copy to the patient at his/her request.

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