Spring Health
60 Madison Ave, 2FL
New York, NY 10010

Spring Health

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

This form is used to advise Spring Health of the person(s) you have chosen to have access to your personal health information.

1. Print Name (First, Middle, Last) of the Spring Health member:

_____

2. Date of Birth (mm/dd/yyyy):

_____

By law, Spring Health must have your written permission (an "authorization") to use or give out your personal medical information, also known as Protected Health Information or PHI, for any purpose that is not set out in the Spring Health Privacy Policy.

In order for Spring Health to disclose your Protected Health Information to another person or entity, you must complete and sign this form and return it to us. You have the right to receive a copy of this form. You may take back ("revoke") your written permission at any time, except if Spring Health has already acted based on your permission.

3. I authorize records for the following period of time to be released (mm/dd/yyyy):

_____ to _____

4. Under this authorization, Spring Health will disclose your entire medical record. **If you do NOT wish for Spring Health to include certain types of information that may be part of your records in the release, please select any type(s) of information you are requesting Spring Health NOT to disclose:**

- ☐ Mental health information
- ☐ Substance Use & Substance Use Disorders (SUD)
- ☐ HIV-related information

5. Disclose my information to:

Print Name (First, Last; entity if applicable):

_____

Name and address (email or fax number):

_____

6. How long should this authorization be in effect?

This form will be valid for one (1) year unless a shorter time period is listed below.

My authorization is valid from (mm/dd/yyyy):

_____ to _____

Re-disclosure: I understand that once Spring Health discloses my information pursuant to this authorization, the information may no longer be protected by federal and state privacy laws and my health information may be re-disclosed.
Revocation: I have the right to revoke (cancel) this authorization at any time by sending a written notice to the Privacy Officer at the address listed at the top of this form, emailing compliance@springhealth.com, or by calling 855-629-0554. I understand the revocation will not be effective until received by the Privacy Officer. Revocation will not affect any action taken by Spring Health in reliance on this authorization prior to receiving my written notice of cancellation**.**
Refusal: If I refuse to sign this form, my treatment, payment, enrollment or eligibility for benefits will not be affected.

I understand and agree that: This authorization is voluntary. My health information may contain records relating to mental and behavioral health, psychotherapy, HIV and /or AIDS diagnosis, and alcohol and substance abuse treatment.

7. Signature of member or authorized representative:
I have read and understand the terms of this form.

_____ _____

Signature **Date (mm/dd/yyyy)**

Note: This form must be signed by either the member or his/her/their personal representative. If you are not the member, please indicate your relationship to the member by checking the appropriate box.

Relationship*:

- ☐ Parent / Legal Guardian
- ☐ Power of Attorney
- ☐ Other*:

*Documentation must be provided supporting your legal authority to act on the member's behalf. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.