Tamber

Authorization to Release Health Information

1. Patient Information

FIRST NAME MI LAST NAME

DATE OF BIRTH PREVIOUS NAME(S)

ADDRESS

CITY STATE ZIP CODE

PHONE E-MAIL (OPTIONAL)

2. I authorize Tamber to release information to the person, organization, or facility named below, either verbally or in writing, as indicated in this authorization.

ORGANIZATION(S) **AND/OR** PERSON NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY STATE ZIP CODE

PHONE (OPTIONAL) FAX (OPTIONAL)

INFORMATION NEEDED BY DATE (OPTIONAL)

3. Information to be Released

I understand that Tamber will release all information that it has retained about my care for all dates of service. This release may include information about clinical history, family history, social history, behavioral history, clinical results, diagnoses, treatment modalities, medications, functional status, treatment plans, symptoms, prognosis, progress notes, alcohol and drug use, billing records, claim records and other information.

4. Health information includes written and oral information

You are giving permission for written information to be released **and** for Tamber and the third party named in section 2 to talk about your health information.

If you do not want to give your permission for Tamber and the third party named in section 2 to talk about your health information, **initial here:** _____

- ## Submission Instructions

  a. Complete all sections of this form
  b. Mail the form to:

  Tamber Health
  PO Box 178
  Crystal Bay, MN 55323

  c. Call us at 855-4TAMBER (1-855-482-6237) in order to pre-pay the copying fee.

Patient Understanding

I understand that by signing this form, I am authorizing Tamber to release information to the person, organization or facility named in section 2.

I may stop this authorization at any time by writing to Tamber and to the person, organization or facility named in section 2. If Tamber or the person, organization or facility named in section 2 has already released health information based on my authorization, my request to stop will not work for that health information.

I understand that when the health information specified in section 3 is sent to the third party named in section 2 above, the information could be re-disclosed by the third party that receives it and it may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 2 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form. Tamber will not condition treatment or payment on whether I sign this form.

If I choose not to sign this form and the organization named in section 2 is an insurance company, my failure to sign this form will not impact my treatment but I may not be able to get new or different insurance and/or I may not be able to get insurance payment for my care.

This authorization will end one year from the date this form is signed unless I indicate a different date or event here:

DATE OR SPECIFIC EVENT

Patient

NAME

SIGNATURE DATE

OR

Legally Authorized Representative

NAME RELATIONSHIP TO PATIENT

SIGNATURE DATE

Sender Contact Information

NAME TITLE

PHONE FAX

EMAIL ADDRESS