Northwinds Integrated Health Network IPA, Inc., Authorization For Release of Information

I _____ authorize Citizen Advocates Inc. to disclose to the entities listed below health information regarding my care and treatment including, but not limited to, clinical notes, discharge summaries, allergies, a history of illness, injuries or medical conditions, test results, treatments you have received, your diagnoses, and a list of medicines you have taken. These records may also include all of this information about sensitive health conditions including, but not limited to:

_____ Substance Use Disorders

_____ Mental Health Conditions

To Northwinds Integrated Health Network IPA, Inc., Adirondacks ACO, LLC and the following addition entities:

This information will be used by the receiving party for lawful purposes, and/or by such organizations contractors of subcontractors of the receiving party for payment or operations including quality assessment and improvement initiatives, utilization review and management services, performance assessments, conducting cost management and planning-related analyses, data analysis and the review of health care services for medical necessity or appropriateness of care and related activities. This information may be released periodically, as needed, to provide those functions.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records and more general laws protecting health information and cannot be disclosed without my written consent unless allowed by such law.

Signing this authorization is voluntary. I understand that my ability to receive services from Citizen Advocates Inc. will not be conditioned on my signing this authorization.

I understand that substance use disorder information may only be re-disclosed if accompanied by required statements regarding prohibition of re-disclosure. I understand that I have the right to revoke this authorization at any time, except for actions already taken in reliance on it. This authorization will remain in effect unless I revoke it.

This authorization will expire after three (3) years unless I indicate a different timeframe, event or date by writing that timeframe, event or date here:_____

My questions about this authorization have been answered. I understand I can receive a copy of this authorization.

Print Name of individual or individuals' legal representative:_____

Signature of individual or individuals' legal representative: _____

Address:_____

Date of Birth: _____

Today's Date: _____/_____/_____
Mo Day Year

Revised 8/4/2022