Authorization for Release of Health Information to AdvoCare Clinic, LLC

Patient Name:	**Date of Birth:**
Patient Street Address:	**Phone Number:**
Patient Email Address:	**City:**
State: Ohio Zip Code:	**Dates of Service: From to**

Health Information to be Disclosed that is Relevant and Supports my following Condition(s): (CHECK ALL THAT APPLY)

☐ AIDS	☐ Fibromyalgia	☐ Positive Status for HIV
☐ ALS- Amyotrophic Lateral Sclerosis	☐ Glaucoma	☐ Post-Traumatic Stress Disorder (PTSD)
☐ Alzheimer's Disease	☐ Hepatitis C	☐ Sickle Cell Anemia
☐ Cancer	☐ Inflammatory Bowel Disease	☐ Spinal Cord Disease or Injury
☐ Chronic Traumatic Encephalopathy	☐ Multiple Sclerosis	☐ Tourette's
☐ Crohn's Disease	☐ Pain That Is Either Chronic & Severe, Or Intractable	☐ Traumatic Brain Injury (TBI)
☐ Epilepsy Or Another Seizure Disorder	☐ Parkinson's Disease	☐ Ulcerative Colitis (UC)
☐ Other (Please Specify):		

Provider Attestation and Detailed Description of Patient's Qualifying Condition(s) for Medicinal Cannabis:

_____

_____

_____

_____

Provider Signature:	Date:

I would like a copy of my medical records forwarded to AdvoCare Clinic immediately by fax at 1-833-488-4621. *Reason for Disclosure: ____
*At my request: ____ *By Checking this Box, I am confirming this is my request.
*Records requested by ACC prior to patient's appointment Date of: _____
Information to be released from (name of provider or medical facility authorized to make disclosure): _____
Provider/Medical Facility Address: _____
Provider/Medical Facility Phone Number: Provider/Medical Facility Fax Number: _____
Patient Medical Record Assigned By This Provider (if known): _____
This information may be disclosed to AdvoCare Clinic. Please Forward or Fax to: AdvoCare Clinic | Attn: Medical Records Department
157 Wilbur Drive NE, 1st Floor | North Canton, Ohio 44720 | Recipient Phone Number: (330) 754-4850 | Recipient Fax Number: 1-833-488-462

I hereby authorize the use of disclosure of personal health information about me as described above. I understand if a request to inspect the records is made, nothing may be removed, taken apart, or noted in or on any portion of the medical record. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such a person or entity and will likely no longer be protected by the federal regulations. As described in the Notice of Privacy Practices of AdvoCare Clinic, LLC, I understand that I may revoke this authorization in writing any time, except to the extent that action has been taken by AdvoCare Clinic, LLC in reliance on this authorization, by sending a written revocation to AdvoCare Clinic, LLC, Medical Records Department, 157 Wilbur Drive NE First Floor, North Canton, Ohio 44720. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire on Patient's death. I understand this authorization is voluntary and AdvoCare Clinic, LLC will not condition AdvoCare Clinic, LLC treatment, payment, enrollment or eligibility for benefits on this authorization. I understand and acknowledge that my medical record may contain information relating to Mental Health, Alcohol/Drug Abuse and/or Human Immune Virus/Acquired Immune Deficiency Syndrome, or other sensitive information, and I expressly consent to the release of any such information contained in the record designated above. This release is sufficient for the purpose of release of Alcohol/Drug diagnosis and treatment, HIV test results or diagnosis. Patient hereby accepts responsibility for any and all cost incurred in the release of their protected health information. **Records are protected under 42CFR, Part 2 regarding substance use disorders.**
If patient's personal representative is signing, please specify description of authority:
If patient's personal representative is signing, please specify description of authority: _____

Patient Signature:	Date: