PO Box 1110
Watertown, MA 02471
Phone: 1-866-679-0831
Fax: 802-332-3117

Authorization to Release and/or Exchange Medical Records

Member name*: _____DOB*: _____ BLP ID No.:_____

☐ ***I authorize Better Life Partners to release my information as described below.**

To*: _____

Address:_____

Phone:_____ Fax:_____Email:_____

☐ ***I authorize the entity listed above to release my information to Better Life Partners as described below.**

Type of information*: ☐ My full medical record, *including my substance use_disorder information* and, if any, *HIV test results*

☐ Other _____
including my substance use disorder information and, if any, *HIV test results*

Date range*: ☐ All dates of service from start of my treatment to the present

☐ Other _____

For the purpose of*: ☐ Continuity of Care ☐ Legal ☐ Other_____

I understand and acknowledge that the requested information may contain information regarding **HIV test results or diagnosis**, **alcohol and/or drug dependence**, physical and mental illness, and genetic testing. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

I understand I am entitled to a copy of this authorization form. I understand that I may see and copy the information described on this form if requested in writing.

I understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.

I understand that I may refuse to authorize the disclosure of some or all of my health care information, but that my refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.

I understand there may be charges for the copying and release of information and accept financial responsibility for those charges.

I understand and agree that a copy of this authorization shall have the same force and effect as the original.

I understand I have a right to revoke this authorization at any time. I can begin the revocation process by calling Better Life Partners at (866) 679-0831, by contacting Better Life Partners by email at records@betterlifepartners.com or by mail at BLP Medical Records Department, PO Box 1110, Watertown, MA 02471. I understand that the revocation will not apply to information that has already been released in response to this authorization.

If not revoked, this authorization will expire **one year from the date of my signature** or on the following date, event or condition (if earlier):_____.

I understand my authorization for financial transactions does not expire.

Member signature*:_____Date*_____

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* Prohibition Against Re-Disclosure: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.
