

### Medical Records Release For Use Or Disclosure Of Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

PATIENT INFORMATION		
PRINT NAME OF PATIENT:		
DATE OF BIRTH:	SSN:	MEMBER ID:

#### I. My Authorization

I authorize the following using or disclosing party:

---

To use or disclose the following health information: *(check one)*

- All of my health information
- My health information relating to the following treatment or condition:  
\_\_\_\_\_
- My health information covering the period from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- Other: \_\_\_\_\_

The above party may disclose this health information to the following recipient:

Name (or title) and organization:  
OneShare Health Clinical Review Department  
PO Box 825  
Uniontown, OH 44685  
Phone: 833-380-9080 Fax: 682-477-3868  
Email: [clinicalreview@onesharehealth.com](mailto:clinicalreview@onesharehealth.com)

The purpose of this authorization is: *(check all that apply)*

- At my request
- Other: \_\_\_\_\_

This authorization ends: *(check one)*

- On (date): \_\_\_\_\_
- When the following event occurs: \_\_\_\_\_

**II. My Rights**

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If the patient is a minor or unable to sign, please complete the following:

- Patient is a minor: \_\_\_\_\_ years of age
- Patient is unable to sign because: \_\_\_\_\_

**Signature of Authorized Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name of Authorized Representative: \_\_\_\_\_

Authority of representative to sign on behalf of the patient:

- Parent
- Legal Guardian
- Court Order
- Other: \_\_\_\_\_

**III. Additional Consent for Certain Conditions**

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

- I consent to have the above information released.
- I do not consent to have the above information released.

**Signature of Patient or Authorized Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**IV. Additional Consent for HIV/AIDS**

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

- I consent to have the above information released.
- I do not consent to have the above information released.

**Signature of Patient or Authorized Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

ONESHARE HEALTH, LLC (ONESHARE) IS NOT AN INSURANCE COMPANY BUT A RELIGIOUS HEALTH CARE SHARING MINISTRY (HCSM) THAT FACILITATES THE SHARING OF MEDICAL EXPENSES AMONG MEMBERS. As with all HCSMs under 26 USC § 5000A(d)(2)(B)(ii), OneShare's Members are exempt from the ACA individual mandate. OneShare does not assume any legal risk or obligation for payment of Member medical expenses. Neither OneShare nor its Members guarantee or promise that medical bills will be paid or shared by the Membership. Available nationwide, but please check [www.onesharehealth.com/legal-notices](http://www.onesharehealth.com/legal-notices) for the most up to date state availability listing.