MARVIX AI

CONSENT TO DISCLOSE INFORMATION TEMPLATE

Questions? Visit us at **www.marvix.ai**

1 PATIENT INFORMATION

NAME

AGE / SEX

PHONE NUMBER

ADDRESS

PA PURPOSE OF CONSENT / AUTHORIZATION

Care coordination, communication with family / caregiver, school or employer documentation, legal or insurance purposes, referral coordination, behavioral health collaboration, or release to a specific third party...

ED PERSON / ENTITY AUTHORIZED TO DISCLOSE

NAME / ORGANIZATION

PHONE

EMAIL

ER PERSON / ENTITY AUTHORIZED TO RECEIVE

RECIPIENT NAME / ORGANIZATION

FAX

ADDRESS

IA INFORMATION AUTHORIZED FOR DISCLOSURE

- [ ] Diagnosis or condition information
- [ ] Medication information
- [ ] Laboratory or imaging results
- [ ] Discharge instructions
- [ ] Treatment plan
- [ ] Appointment information
- [ ] Progress notes
- [ ] Billing or insurance information

- [ ] School / work restriction information
- [ ] Substance use disorder treatment information (if separately authorized)
- [ ] Genetic testing information (if authorized)
- [ ] Behavioral health information (if authorized)
- [ ] HIV/AIDS-related information (if authorized)
- [ ] Other

Other — specify:

IE INFORMATION EXCLUDED FROM DISCLOSURE

- [ ] Behavioral health records
- [ ] Substance use disorder treatment records
- [ ] Genetic testing information
- [ ] Billing records
- [ ] Psychotherapy notes
- [ ] HIV/AIDS-related information
- [ ] Reproductive health information
- [ ] Other sensitive information

Other excluded — specify:

PU PURPOSE / METHOD / SCOPE / EXPIRATION

7a PURPOSE OF DISCLOSURE

Purpose:

7b METHOD OF DISCLOSURE

- [ ] Verbal communication
- [ ] Fax
- [ ] Patient portal message
- [ ] Mail
- [ ] Written summary
- [ ] Secure email
- [ ] Phone call
- [ ] In-person discussion

Preferred Method:

7c DATE RANGE / SCOPE

FROM

TO

- [ ] Single encounter only
- [ ] Ongoing care coordination
- [ ] Specific condition or treatment episode only
- [ ] Current episode of care only
- [ ] Entire medical record

7d EXPIRATION OF CONSENT

Expiration Date:

7e RIGHT TO REVOKE

Submit written revocation to (Address / Fax / Email):

RS REDISCLOSURE NOTICE / PATIENT RIGHTS

Redisclosure: Information disclosed may be redisclosed by the recipient and may no longer be protected by HIPAA. **Patient Rights:** Signing is voluntary. Patient may refuse to sign. Refusal generally does not affect treatment, payment, or eligibility for benefits. Patient may request a copy of this signed consent. Patient may revoke consent in writing at any time. Only information specifically authorized may be disclosed.

SG PATIENT / LEGAL REPRESENTATIVE SIGNATURE

PATIENT SIGNATURE

PRINTED NAME

9a IF SIGNED BY LEGAL REPRESENTATIVE

REPRESENTATIVE NAME

RELATIONSHIP / AUTHORITY

PHONE NUMBER

DATE

WS WITNESS / STAFF VERIFICATION

WITNESS / STAFF NAME

SIGNATURE

DATE

TIME

FO FACILITY USE ONLY

CONSENT RECEIVED DATE

REPRESENTATIVE AUTHORITY VERIFIED

DATE OF DISCLOSURE

RECIPIENT CONFIRMED

NOTES