AIS Healthcare
Targeted Drug Delivery®

Advanced
Nursing Solutions

PLEASE COMPLETE FORM IN ITS ENTIRETY;
RETURN VIA FAX: 844.852.5125 OR EMAIL:
AISMEDICALRECORDS@AISCAREGROUP.COM

COMMUNICATION RELEASE FORM

The AIS Healthcare brand is composed of the following businesses: Advanced Infusion Solutions-Targeted Drug Delivery ("TDD"), Advanced Infusion Care ("AIC"), and Advanced Nursing Solutions ("ANS").

Patient name: _____
First Middle Last

Home address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ DOB: _____

THIRD-PARTY AUTHORITY - SPECIFY INFORMATION TO BE VERBALLY DISCLOSED

Indicated below are the third parties who have been given authority to sign and/or communicate on my behalf.

Name of third party	Relationship	Reason	Patient initials

Information authorized: ☐ Medical ☐ Financial ☐ Both ☐ Other: _____

Name of third party	Relationship	Reason	Patient initials

Information authorized: ☐ Medical ☐ Financial ☐ Both ☐ Other: _____

AUTHORIZATION TO ACCEPT DELIVERY OF MEDICATION, EQUIPMENT, AND/OR SUPPLIES

Indicated below are the names of family members, neighbors, or friends who can accept deliveries on my behalf.

Name	Relationship	Patient initials

AUTHORIZATION TO LEAVE INFORMATION

Method in which my health information may be communicated (please check all boxes that apply):

	Indicate if acceptable or not		Patient initials
☐ Home phone: _____	☐ Yes	☐ No	
Home voicemail	☐ Yes	☐ No	
☐ Cell phone: _____	☐ Yes	☐ No	
Cell phone voicemail	☐ Yes	☐ No	
Text message to cell phone	☐ Yes	☐ No	
☐ Email: _____	☐ Yes	☐ No	
☐ Fax: _____	☐ Yes	☐ No	
☐ Mail: _____	☐ Yes	☐ No	

Advancing quality. Improving lives.

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TERM

This Authorization will remain in effect (please select 1):

☐ until discharged* from services or ☐ from the date of this authorization until _____, 20____.

*Discharged is defined as an inactive patient in AIS Healthcare's system.

DISCLOSURE

I understand that once the Company discloses my health information to the recipient, the Company cannot guarantee that the recipient will not re-disclose my health information to a third party. Further, the third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information. However, if my information includes alcohol or drug abuse treatment program records or information, the confidentiality of the records or information is protected by federal law (42 C.F.R. Part 2) that prohibits re-disclosure except with my specific written consent.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at the Company; except, however, if my treatment at the Company is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Company may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Company's Compliance Office at the address listed below. The revocation will be effective immediately upon the Company's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Company in reliance on this Authorization before it received my written notice of revocation.

I may contact the Company's Compliance Department by email at compliance@aiscaregroup.com, by mail at 623 Highland Colony Parkway, Suite 100, Ridgeland, MS 39157 or by telephone at 877.443.4006.

AUTHORIZATION

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize the Company to use or disclose my health information in the manner described above.

Signature of Patient _____ Date _____

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Authorized Personal Representative _____ Relation to Patient _____ Date _____

Please complete the form in its entirety. Return completed forms by fax or email.
Fax: 844.852.5125
Email: aismedicalrecords@aiscaregroup.com

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