



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: \_\_\_\_\_

**SPECIFY INFORMATION TO BE VERBALLY DISCLOSED**

The information that may be verbally disclosed under this authorization includes medical and financial. **If you wish to exclude any information from being disclosed, check box below (please check all boxes that apply):**

- Medical
- Financial
- Other: \_\_\_\_\_

**THIRD-PARTY AUTHORITY**

Indicate below the names of third parties who have been given authority by the patient to sign and/or communicate on his/her behalf and the reason.

Name of third party	Relationship	Reason	Patient initials
_____	_____	_____	_____
_____	_____	_____	_____

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

Indicate below the names of family members, neighbors, or friends who can accept deliveries on your 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
<input type="checkbox"/> Home phone: _____ Home voicemail system	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Cell phone: _____ Cell phone voicemail system Text message to cell phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Email: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Fax: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Mail: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> 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@aiscargroup.com](mailto:compliance@aiscargroup.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 FORM IN ITS ENTIRETY; RETURN VIA FAX: 844.852.5125  
OR EMAIL: AISMedicalRecords@aiscargroup.com**