Authorization to Release Health Information

I HEREBY AUTHORIZE THE DISCLOSURE OF INFORMATION FROM MY HEALTH RECORD:

Patient Name (Last, First)	
Date of Birth	**Phone**
Address	
City, State ZIP	

I, the undersigned, understand that I have the right to:
- refuse to sign this authorization
- receive a copy of this authorization
- restrict what is disclosed by this authorization
- inspect or request an amendment of the health information to be disclosed
- revoke this authorization, by written notice
- know about any compensation the practitioner/facility will receive resulting from the release of my health information

YOU MAY OBTAIN HEALTHCARE INFO FROM:

Clinic/Provider
Address
City, State ZIP
Phone

YOU MAY SEND HEALTHCARE INFORMATION TO:

Clinic/Provider
Address
City, State ZIP
Phone

TYPE OF INFORMATION REQUESTED (check all that apply)

☐ Verbal	☐ Medication & Supplementation	☐ Operative/Procedure Reports
☐ Written	☐ History & Physical Examination	☐ Lab (Test) Results
☐ Consultation	☐ Progress (Chart) Notes	☐ Other:

Specific Dates of Treatment: _____.

PURPOSE FOR WHICH INFORMATION IS BEING RELEASED (check one)

☐ My doctor/continuation of care	☐ Myself	☐ Insurance Claim	☐ Legal	☐ Other (specify): _____.

I understand this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing/treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse, and mental health conditions. I recognize that once disclosed my health information is no longer under the control of this practitioner/facility. While I understand that the practitioner/facility will make a good faith effort to release my information only to trusted recipients, my health information may be re-disclosed by subsequent parties, and thus may no longer be protected by this office's privacy practices. I release Black Pine Holistic Healing, its employees, and practitioners from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that whether or not I sign this document will not effect my treatment at this practice, the payments I incur here, or my eligibility for benefits of any sort. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Rights for my state at: http://www.hhs.gov/ocr/regmail.html.

EXPIRATION DATE OR EVENT: _____.
(The authorization will expire at the end of this period.)

_____ _____
Signature of Patient (or authorized representative) Date

_____ _____
Signature of Practitioner or Facility Representative Date