HIPAA AUTHORIZATION / RELEASE OF INFORMATION

Authorization to Obtain, Release, or Exchange Health Information

PATIENT INFORMATION

Patient Full Legal Name: _____

Date of Birth: _____ **Telephone:** _____

Address: _____

DIRECTION OF AUTHORIZATION

I authorize the following action(s):

☐ RELEASE records FROM Holistic Origin Her Wellness™ ☐ OBTAIN records FOR Holistic Origin Her Wellness™

☐ TWO-WAY EXCHANGE of the information described below

PERSON / ORGANIZATION AUTHORIZED TO DISCLOSE INFORMATION

Identify the healthcare professional, practice, facility, laboratory, or other person/entity authorized to disclose the information.

Name / Organization: _____

Address: _____

Telephone: _____ **Fax:** _____

Secure Email, if applicable: _____

PERSON / ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION

Identify the person or organization authorized to receive the information.

Name / Organization: _____

Address: _____

Telephone: _____ **Fax:** _____

Secure Email, if applicable: _____

INFORMATION AUTHORIZED

Select only the information you want disclosed or exchanged.

☐ Entire medical record / complete patient file

☐ Consultation notes ☐ Laboratory results ☐ Imaging reports

☐ Medication / supplement list ☐ Problem / diagnosis list ☐ Immunization information

☐ Reproductive / fertility records ☐ Menopause-related records

☐ Billing / payment records ☐ Other

If Other, describe: _____

Date range, if applicable:

From: _____ To: _____ ☐ All available dates

PURPOSE OF THE DISCLOSURE

☐ At my request ☐ Consultation / care coordination ☐ Personal use

☐ Legal / administrative purpose ☐ Other

If Other, describe: _____

SENSITIVE INFORMATION

Some health information may be subject to additional federal or state privacy protections. To the extent a separate or more specific authorization is required by applicable law, Holistic Origin Her Wellness™ will obtain or require the appropriate authorization before disclosure.

If you specifically want sensitive information included, indicate below where applicable:

☐ HIV / AIDS-related information ☐ Mental / behavioral health information

☐ Substance use disorder information ☐ Genetic information ☐ Reproductive / sexual health information

Selection of a category above does not authorize disclosure beyond what applicable law permits and does not replace any separate consent language legally required for that category.

EXPIRATION

This authorization will expire on the following date or when the following event occurs:

Expiration Date or Event: _____

If no expiration is entered, this authorization may be considered incomplete or invalid where an expiration date or event is required.

YOUR RIGHTS & IMPORTANT INFORMATION

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.
- To revoke this authorization, I may submit a written revocation to Holistic Origin Her Wellness™ using the Practice's designated privacy contact or another approved method.
- I understand that signing this authorization is voluntary. Holistic Origin Her Wellness™ generally will not condition consultation services or payment on my signing this authorization, except where applicable law permits otherwise.
- I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by the HIPAA Privacy Rule, although other federal or state privacy laws may continue to apply.
- I understand that I am entitled to a copy of this signed authorization.
- I understand that this authorization applies only to the information, persons/organizations, purpose, and time period described in this form.

PATIENT AUTHORIZATION

By signing below, I authorize the use and/or disclosure of the health information described in this form.

Patient Name: _____

Patient Signature: _____

Date Signed: _____ **Time (optional):** _____

PERSONAL REPRESENTATIVE — IF APPLICABLE

Complete this section only if someone legally authorized to act for the patient is signing.

Representative Name: _____

Relationship to Patient: _____

Authority to Act for Patient: _____

Representative Signature: _____

Date: _____

PRACTICE USE

□ Identity / authority verified □ Authorization reviewed for completeness

Processed by: _____ **Date:** _____

Notes: _____

PRACTICE CONTACT

Holistic Origin Her Wellness™

Privacy Contact/Official: _____

Email: _____

Telephone: _____

Website: www.holisticoriginherwellness.com