Authorization to Disclose Protected Health Information

Authorization for use or disclosure of protected health information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and164)

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

I authorize West Valley Naturopathic Center to use and disclose my healthcare information to:

Individual/Facility/Provider Name: _____

Self: _____ (place check mark here)

Phone: _____

Address: _____

This authorization shall be in force and effect until _____(date), at which time this authorization expires.

This authorization for release of information covers the period of healthcare from

_____ to _____ or ____ all past, present and future periods

You must initial each of the following individually for the information to be released:

_____ HIV/AIDS _____ Mental HealthRecords

_____ Drug/alcohol diagnosis and treatment. _____ Genetic Testing

Federal Regulation requires a description of how much information and what kind of information

you would like disclosed: _____

I understand that I have the right to the following:

- Revoke this authorization by sending written notice to this office. I understand that a revocation is not effective to the extend that any person or entity has already acted in reliance of my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and insurer has a legal right to contest a claim
- Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization and a a result of authorization
- Inspect a copy of Patient Health Information being used or disclosed under Federal Law
- Refuse to sign this authorization
- Receive a copy of this authorization
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on wether I sign this authorization
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law

_____ _____

Signature of patient or personal representative **Date**

_____

Printed name of personal representative