HIPAA AUTHORIZATION TO RELEASE HOLISTIC2HEALTH RECORDS

Date:_____

Clinic Location(s) Authorized to Make the Requested Disclosure: _____

Patient Name:_____**Date of Birth:** _____

Address:_____**Phone:** _____

I authorize the release of my medical information specified below from the above listed Holistic2Health Wellness Center Clinic Location to:

Name of Person or Entity whom Holistic2Health May Make the Requested Disclosure:

_____

Address:

_____

Phone:_____**Purpose for Disclosure:** _____

Date Range: From_____to_____.

RECORDS TO BE RELEASED

☐ Entire Medical Record/Complete Patient File

If you are not requesting the entire medical record/complete patient file, please select or list specific documents to be requested **(check all that apply)**:

☐ Patient Intake Paperwork

☐ Patient Signed Consents

☐ X-Ray Films

☐ Physician Notes

☐ Correspondence

☐ Examinations/Consultations

☐ Treatment Plans/Prescriptions

☐ Reports

☐ Bills/Invoices/Payments

☐ Other: _____
(Please list.)

1610 LaVista Rd NE | Suite 9 | Atlanta, GA 30329 | phone: 678-632-6212
Submit by email at drlatrice@h2hwellnesscenters.com

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METHOD OF DELIVERY

(Please select only one.)

☐ U.S. Mail ☐ Fax*

☐ Email* ☐ Other: _____

***Records Disclosed by Email or Fax**: I authorize the above requested records to be disclosed electronically to the following email address or fax number:

Email or Fax Number:_____**Patient Initials:** _____

Email or Fax Acknowledgement:
I, the undersigned, warrant that I am the only person or entity that has access to the email address or fax number as provided above.

Name:_____**Signature**:_____
(*Person or Entity Receiving Email or Fax)*

I understand that:

- The information in my record may contain information regarding sexually transmitted diseases or HIV/AIDS. My record may also contain information about mental health services or treatment for alcohol and drug abuse.
- I am not required to enter into this Authorization, and my medical provider may not condition treatment, payment for treatment, enrollment or eligibility for benefits on whether I sign this Authorization. However, Holistic2Health is allowed by law to disclose information regarding treatment, payment, or health care operations without your consent.
- This Authorization will expire one year from the date of signature below. I may revoke this Authorization at any time in writing to the healthcare provider, except to the extent Holistic2Health has already relied on my authorization, and Holistic2Health has not had a reasonable opportunity to act when it receives the revocation.
- Federal privacy regulations will no longer apply to the information disclosed, and the information disclosed to the recipient may be re-disclosed to others.
- A copy of this Authorization is as valid as the original Authorization.
- I am entitled to a copy of this Authorization.

_____ _____
Patient Signature Date

_____ _____
Printed Name Relationship to Patient

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