AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

atient making authorization:
ıll Name:
rth Date (MM/DD/YYYY):
ddress:
Phone Number:
ealthcare provider or entity authorized to disclose this information:
inic/Provider Name:
ıone Number:
ddress:
Fax Number:
ealthcare provider or entity authorized to use this information:
inic/Provider Name: BioIntelligent Wellness
ıone Number: 858-228-3644
ddress: 124 Lomas Santa Fe Drive, Suite 206 Solana Beach, CA 92075
Fax Number: 760-994-1298
ɔecific information to be disclosed (check one):
Medical record from (insert dates):
Entire medical record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, lling records, insurance records, and records received from other healthcare providers.
to:
eason for release of information: Participation in a supervised weight loss and wellness program.
ıe individual signing this form agrees to and acknowledges the following:
Voluntary authorization: This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as ɔplicable) will not be conditioned upon my signing this authorization form.
Effective time period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient r whom this authorization is made or the following specified date: _____
Right to revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care ovider or entity listed above. I understand that I may revoke this authorization except to the extent that action has ready been taken based on this authorization.
Signature authorization: I have read this form and agree to the uses and disclosure of the information as described. I ıderstand that refusing to sign this form does not stop disclosure of health information that has occurred prior to vocation or that is otherwise permitted by law without my specific authorization or permission. I understand that formation disclosure pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be otected by federal or state privacy laws.

gnatures:	
atient/Legal representative:	
legal representative, relationship to patient:	
itness (optional):	Date:
gnature of minor (if applicable):	Date:

ote: A minor individual's signature may be required for the release of certain types of information, including, for example, e release of information related to certain conditions or circumstances. Please refer to the current laws in this regard and, determined to be a requirement, have minor sign below.