

Wells Institute for Health Awareness

HIPPA Authorization form

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Wells Institute for Health Awareness** to use and/or disclose certain protected health information (PHI) about me to the following locations:

Telephone Communication: Home/Cell Phone _____
 Work Phone _____

Written Communication: Email _____
 Mail to home address _____
 Fax _____

This authorization permits **Wells Institute for Health Awareness** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

I do not have to sign this authorization in order to receive treatment from **Wells Institute for Health Awareness**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Wells Institute for Health Awareness
513. E. Stroop Rd., Kettering, OH 45429
937-293-2157

Patient Signature (or legal guardian)

Print Patient's Name

Date

Print Name of Patient or Legal Guardian (if applicable)

Relationship to Patient

Wells Institute

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____