



Four Seasons Wellness

Authorization for Disclosure of Protected Health Information

Patient Name: _____	Date of Birth: _____
Full Address: _____	
Phone Number: (Home) _____	(Mobile) _____
Maiden/Previous Name: _____	

Instructions: Fill out each section of the form in its entirety. *Failure to do so may delay processing of your request.*

Release Information From:

Name/Facility: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Release Information To:

Name/Facility: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Purpose of Release:

<input type="checkbox"/> Continue Medical Care	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Other _____
<input type="checkbox"/> Insurance Claim	<input type="checkbox"/> Disability Determination	_____
<input type="checkbox"/> Application for Insurance	<input type="checkbox"/> Personal	_____

Delivery Method: Date Information desired by: _____

Release Format (Check 1 of 2 options only):
1. <input type="checkbox"/> Paper via <input type="checkbox"/> Mail OR <input type="checkbox"/> Pick Up
2. <input type="checkbox"/> Fax (as appropriate) Fax #: _____

Information to be Released:

Service Dates: From: _____ To: _____ OR			
<input type="checkbox"/> all future records until this authorization expires			
NOTE: This authorization expires ones year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> ER Records	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Clinic Visit Notes
<input type="checkbox"/> Psychological Evals/Assmts	<input type="checkbox"/> EKG/Cardiology Reports	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Operative Records
<input type="checkbox"/> Lab/ Pathology Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Entire Medical Record
<input type="checkbox"/> Billing Statements (<i>Charges may apply</i>)	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Alcohol/Drug Treatment Records: _____			

I AUTHORIZE RELEASE OF ALL ALCOHOL AND /OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____ **Do not release alcohol or drug treatment records protected under federal law.**

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release of Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature (required): _____	Date Signed (required): _____
Printed Name of Person Signing (If not patient): _____	