AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information

Name: ____

Date of Birth: ____

Social Security Number: _____________________________________

Address: ____

Healthcare Provider Authorized to Release Information

I authorize the following person and/or organization to disclose the health information described herein:

Name: Whole Health Private Family Practice and Urgent Care

Address: 402 SE 6th Ave, Suite A, Delray Beach FL 33483o

Authorized Recipient of Medical Records

I authorize the following person and/or organization to receive the health information described herein:

Name: ____

Address: ____

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCLOSE MY MEDICAL RECORDS TO ANYONE OTHER THAN THE AUTHORIZED RECIPIENT SPECIFIED HEREIN.

Reason for Release of Information

The release of this information is made at the request of the undersigned individual due to the closure of Whole Health Private Family Practice and Urgent Care.

Scope of Authorization

I hereby authorize the healthcare provider identified above to disclose the following specific information:

- ☐ Entire medical record with no date restrictions
- ☐ Medical record from ______________ (beginning date) to _____________ (end date)
- ☐ Other: ____

"Medical record" includes patient histories, patient questionnaires, intake information sheets, office notes (except psychotherapy notes), consultations, test results, laboratory reports, radiology studies or reports, pathology reports, x-ray reports, films, diagnostic tests, referrals, medication records, prescription and pharmacy records, assessments, treatment plans (including treatments prescribed, performed, or recommended), diagnosis or prognosis information, periods of stays or hospitalization, discharge summaries and instructions, progress notes, billing and

payment records, insurance records, correspondence, records sent to you by other healthcare providers, computer data or compilations or reports, and all other forms or documents.

Expiration of Authorization

This authorization shall remain in effect for one year or unless otherwise terminated by me by providing written notice.

Patient Certification and Acknowledgment of Understanding

I request that health information regarding my care and treatment be released as set forth on this form. I certify that I am the patient, and the identification that I have provided is true and correct.

In accordance with Florida Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand and agree with the following statements:

- **Alcohol and drug abuse, mental health, and HIV-related information**. This authorization may include disclosure of information relating to alcohol and drug abuse, mental health, and HIV-related care, testing, or treatment. I specifically authorize the release of this information to the authorized recipient indicated above.
- **Redisclosure**. I understand that any information disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.
- **Revocation**. I have the right to revoke this authorization, in writing, at any time, except to the extent that the healthcare provider identified above has acted in reliance upon it, by sending written notification to the healthcare provider identified above.
- **Authorization is voluntary**. I understand that signing this authorization is voluntary.
- **Copy**. I agree that a copy of my signature will be treated as an original signature, and I understand that I have received a copy of this authorization.

__________________________________ __________________________________

Signature of Patient or Authorized Representative   Printed Name of Patient or Representative

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Date of Signature

Mail:	Fax:	Email:
402 SE 6the Ave, Suite A, Delray Beach FL 330483	561-330-9011	