AUTHORIZATION FOR USE OR DISCLOSURE (RELEASE) OF/ REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Section A: Must be completed for all authorizations/requests

I hereby authorize the use or disclosure of my individually identifiable health information as described below:

Patient Name (Printed): ______________________________ Date(s) of service: ________________
ID Number (if known) ______________ Birth Date: ___________ Phone Number: ________________

Persons/organizations receiving the information:

Forbes Wellness, LLC
P.O. Box 828
Occoquan, VA 22125-0828
Ph: (703)690-8482
Jill Forbes, A-CNP fax (701)248-9320

Persons/organizations providing the information:

Name: ___________________________
Address: __________________________
____
____
Phone: ___________________________

Information Requested:

__ Entire Medical Record
__ Entire Billing Record
__ Physician Orders
__ Progress Notes
__ Consultation Reports
__ History and Physical
__ Discharge Summary
__ Operative Reports
__ Immunization Records
__ Other
__ Laboratory Reports
__ Radiology Reports
__ Pathology Reports
__ EKG, EEG, EMG Reports

Section B: Must be completed for all authorizations/requests

The patient or the patient's representative must read and agree to the following statements:

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law, including research related treatment which may be conditioned upon this authorization. Forbes Wellness, LLC however may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signature of this authorization.

I understand that information released according to this authorization may lose the protections of federal privacy regulations due to re-disclosure by the recipient. Access to medical records may be subject to additional state and federal regulations.
I understand that this disclosure may include information regarding drug and alcohol abuse, HIV / AIDS, psychiatric and/or mental illness,industrial accidents, disability, birth defects, cancer and genetic information.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions taken before receiving the revocation.

Signed:____Dated:____________________

(Patient or Representative)
Name of representative:___________________________ Relationship: ____________________
Phone Number:____________________ Address:____________________________________