Jennifer Armstrong, ARNP

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, ______________________________ ______________________________ authorize Encore Wellness to:

(Patient's Name) (Date of Birth)

☐ Release Information to: Obtain information from:

Physician or Recipient: ______________________ Phone: ______________ Fax: ______________

Address. ____

☐ By initialing in the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist. I understand there may be a fee for this service.

_____Entire medical records (all information except for sensitive records unless initialed in next section) _____Most recent two-year history
_____Laboratory and/or pathology reports ONLY Other
____

☐ The following items must be initialed to be included in the use or disclosure of other health information:

*HIV/AID related health information and/or records
_____*Sexually transmitted disease information and/or records
*Mental health information and/or records
*Genetic testing information and/or records
_____
_____*Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal Law prohibits the re-disclosure of such information.)

This information is being released/obtained for the following reason(s): ______________________________
Transferring care to another primary care provider/doctor will terminate your care at Encore Wellness 4 Life, LLC. You will no longer be considered a patient and you will not be able to schedule after the transfer date. Exceptions may apply.

I understand that I may revoke this authorization at any time by giving written notice to Encore Wellness 4 Life, LLC (unless action has already been taken in reliance upon this authorization). Unless revoked earlier, this authorization will expire 180 days from the date of signing or ______________________

I understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility benefits. I also understand if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Print Name of Legal Representative (if applicable) ______________________ ______________________ Relationship to Patient

____ ______________________
Patient/Legal Representative Signature Date

IF PATIENT HAS REACHED HIS OR HER 14TH BIRTHDAY, ONLY THE PATIENT MAY AUTHORIZE DISCLOSURE

Encore Wellness 4 Life, LLC
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