Connected Whole Health
at University of Western States

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

As required by Privacy Regulations, Connected Whole Health may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

Patient Name: _____

Date of Birth: _____ Date of Request: _____

I hereby authorize Connected Whole Health and any of its employees to use or disclose my Protected Health Information to the following person(s), entity(s), or business associates of their office:

Name: _____

Address: _____

Phone Number: _____

By **initialing** the spaces below, I specifically authorize Connected Whole Health to release the following records:

_____ Medical records needed for continuity of care

_____ Laboratory records

_____ X-ray(s) and/or imaging including reports (don't send films over 2 years old)

_____ Other: _____

For the specific purpose of (describe in detail) _____

_____

I understand I have the right to: Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization; Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization; Inspect a copy of Protected Health Information being used or disclosed under federal law; Refuse to sign this authorization; Receive a copy of this authorization; Restrict what is disclosed with this authorization. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information. Unless revoked earlier, this consent will expire 180 days from the date of signing. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

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