Authorization to Disclose Protected Health Information

Patient Name**:**_____Address:_____

Phone: _____-_____ Date of Birth: _____/_____/_____

I hereby authorize:

To disclose my health records to:

Dr. Julia Parke ND
1619 BeagleCt
Ventura CA 93003
nfm281@gmail.com

_____

*By **initialing** the spaces below, I authorize the release of the following records, if such records exist:*

____ Entire medical record ___ Progress notes ___Laboratory report

____ Pathology reports ___ EKG ___X-ray

____ Operative report ___ Other, Please be specific:_____

The following items must be **initialed** to be included in other documents:

___ HIV/AIDS related record ___Mental Health records

___ Drug/Alcohol diagnosis, treatment or referral information ___Genetic testing information

(Federal regulations require a description of how much information and what kind of information is to be disclosed).
Describe: Naturopathic Medicine consultation

This authorization 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.

I understand I have the right to:

1. 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.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. 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 patient health information.

_____

Signature of Patient or Patient's Authorized Representative (relationship) *Date* _____/_____/____