Healthcare Disclosure Authorization

Today's Date: _____

Client Information

Client Name: _____ DOB: _____

Previous Name: _____ SSN#: _____

Please choose ONE of the three options below:

☐ I request and authorize WellQuest Medical and Wellness to **release** healthcare information to myself.

☐ I request and authorize WellQuest Medical and Wellness to **release** my healthcare information to the below-named entity.

☐ I request and authorize WellQuest Medical and Wellness to **obtain** my healthcare information from the below-named entity.

Physician / Office Name: _____

Phone: _____ Fax: _____

Address: _____

Please choose ONE of the two options below:

☐ This authorization applies to all healthcare information.

☐ This authorization applies to healthcare information relating to the following treatment, condition, or date range:

_____

_____

Reason for release (required): _____

_____

Information excluded from this release: _____

_____

Conditions of Authorization

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

This authorization is valid for one year for the release of information as indicated above. **Only records from this facility can legally be released.** Any records from other physicians must be obtained from their office, directly.

I understand that information disclosed to parties other that health care providers, health plans, of health care clearinghouses may no longer be protected under federal privacy standards and that my health information may potentially be re-disclosed without obtaining my authorization.

Client Signature: _____ Date: _____

Request Received By: _____

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