Tree Of Life Center for Wellbeing HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Social Security Number/Medical Record Number**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Dana Tavares LMT (DBA Tree of Life Center for Wellbeing)

   10 Mills Rd PO Box 502
   Address

   Newcastle, Me 04553
   City, State Zip Code

3. **The specific information that should be disclosed is (please give dates of service if possible):**

   ◇ Patient health information and medical records including treatment notes and summaries for the purpose of insurance claims or interdisciplinary communications.

   This information is limited to the following records and type of information:

   All medical records pertaining to examination, treatment, consultation, billing, x-rays and reports, history, laboratory findings, admission and discharge reports, treatment records, diagnosis and prognosis recorda, nurses and doctor's notes, all medical reports, photographs, digital or other images.

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *_____
   NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____ .
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

_____	_____	_____
Received	**Processed By**	**Log #**