RECORDS REQUEST

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____
First Middle Initial Last

Birthdate:_____ **Phone:**_____

Information to be released from:

Dr._____ **Agency**_____

Street_____ **City**_____ **State**_____ **Zip**_____

Phone ( )_____ **Fax ( )**_____

Please mail or fax a copy of my records to:

HIGHLAND SPRINGS WELLNESS CENTER
1061 E. Main Street, Suite 204
Grass Valley, CA 95945 **Phone: 530-274-2274** **Fax: 530-274-2559**

As required by the Privacy Regulations, Highland Springs Wellness may not use or disclose my protected health information without my authorization except as provided in the Notice of Privacy Practices.

Purpose of Release: __X__**Consultation** _____**Patient Request** _____**Second Opinion**

Information to be released: _____**All Records** _____**Lab Results** __X__**X-Ray Reports**
__X__**Diagnosis** __X__**Last Chart Notes**

This authorization is valid for one year from the date of consent. I understand that I am entitled to a copy of this authorization upon request. This authorization may be revoked by me at any time in writing, and that revocation will not affect this office's previous reliance on the uses or disclosures pursuant to this authorization.

I understand that the information disclosed above might be re-disclosed to additional parties and no longer protected for reasons beyond the control of HSWC. I further release HSWC and its facility and employees from any liability arising from the release of information to the person/agency designated above.

I understand that I have the right to any knowledge of any remuneration involved due to any marketing activity as allowed by and as a result of this authorization. I understand that under federal law I have the right to inspect a copy of my health information being used or disclosed. I understand that I can restrict what is disclosed with this authorization.

I the undersigned authorize you to release any and all medical records in your possession, as indicated. Such records may include and/or contain reference to psychological information; drug, alcohol, and/or substance abuse history; sickle cell disease; and/or testing for HIV virus and/or AIDS.

_____

Signature of Patient/Parent/Guardian **Date**