True Health
NATUROPATHIC MEDICINE
Nutrition Counseling · Dispensary

PO Box 424 | 11355 County Road K
Boulder Junction, WI 54512
Ph. (715)350-7880 Fax (715)350-7878

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1.

Name of Patient

Street Address

City, State, Zip code

Date of Birth

Phone #

I authorize the use and/or release of my protected health information as described below. I understand that if I sign this authorization, I will be provided with a copy of it. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment. I have the right to revoke this Authorization by providing written notice to True Health Naturopathic Medicine. Revocation of this Authorization will not affect any action taken before receipt of the written revocation. I understand that the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient and or no longer protected by Federal Privacy standards.

2. AUTHORIZE:

(Name of Physician/Health Care Facility/Other)

(Street Address)

(City, State, Zip code)

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
(If Release is to Self, State Self)

Dr. Tricia Paulson, True Health
(Name of Physician/Health Care Facility/Other)

11355 County Road K
(Street Address)

Boulder Junction, WI 54512
(City, State, Zip code)

4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

❑ Transferring to New Physician/Continued Medical Care (customary to release up to 2 years of most recent information)

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Upcoming Appt Date _____

❑ Other (specify): _____

5. HEALTH INFORMATION TO BE RELEASED:

Office Visits: ❑ Primary Care ❑ Specialty (specify) _____ ❑ Procedures

❑ Immunization Records ❑ Lab Reports ❑ X-ray Reports ❑ X-ray Films (specify) ❑ Billing Records (specify)

❑ Specific information related to: _____

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From:_____/_____/_____ (MM/DD/YYYY) To: _____/_____/_____

5a. Federal and state laws require special permission to release certain information. Please check if these records should be released:

❑ Mental Health ❑ Alcohol and/or Drug Abuse ❑ HIV/AIDS Test Results ❑ Developmental Disabilities

6. FORMAT FOR RECORDS: ❑ Paper ❑ DVD

7. EXPIRATION

This authorization will expire on _____/_____/_____ (MM/DD/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below. A photocopy of this authorization is as valid as the original.

8. SIGNATURE

I understand that this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

(4/13) YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

True Health recognizes the patient's right to confidentiality of their health information under federal privacy regulations and Wisconsin law. The patient should be aware of the following information when requesting or releasing health information.

- **Right to Refuse to Sign This Authorization:** A patient may refuse to sign this Authorization and this refusal will not affect the patient's ability to obtain treatment or payment of claims.
- **Right to Inspect or Copy the Health Information to Be Used or Disclosed:** A patient has the right to inspect or copy the health information they have authorized to be used or disclosed by signing this Authorization form. A patient may arrange to inspect their health information by contacting the office listed below.
- **Right to Receive Copy of This Authorization:** A patient has the right to receive a copy of the signed Authorization form.
- **Right to Revoke This Authorization:** A patient has the right to revoke this Authorization at any time by giving written notice of revocation to the Privacy Officer listed below. Revocation of this Authorization **will not** affect any action taken in reliance of this authorization before receipt of the written notice of revocation.
- **Multiple Releases of Information:** A patient may request multiple releases of the information stated on the Authorization form. However, all releases based on this form are limited to records dated up to and including the date of the patient's signature. A new Authorization is necessary for release of information for care provided after the date of the patient's signature, unless the Authorization specifically states that specific records that will be generated in the future may be released, for example "future records of a specific test" or "future records of specific clinic appointment."
- **Who May Sign This Authorization:**
  1. Generally, all patients 18 years of age and older must sign for release of their own health information unless the following conditions apply.
     a. The patient is incompetent
     b. The patient is disabled and cannot sign the form
     c. The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If there is no surviving spouse or personal representative, then an adult member of the immediate family may sign.)
  2. All persons signing for release of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient.
  3. Minors: Patients less than 18 years of age must sign for release of their health information in the following cases:
     a. Alcohol or other drug abuse treatment: age 12 or older
     b. Mental health treatment: age 14 or older may consent to release of records without parental consent (Parents also retain the right to access this information.)
     c. HIV test results: age 14 or older
     d. Emancipated minors who are married or in the military