Affinity Wellness Consultants, LLC
Dr. Amber Manning, DNP, APRN, FNP-C

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:
Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address:_____ City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:
Name: _____
Address:_____City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:
Name: _____
Amber Manning_____
Address:_____City:_____ State:_____ Zip Code:_____
Phone: (302)_569-9355_____ Fax: (1888)_641-3582_____

Specific information to be disclosed:
□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: _____

Include: (*Indicate by Initialing*)	**Reason for release of information:** *(Choose all that Apply)*
_____ Drug, Alcohol or Substance Abuse Records	□ Treatment/Continuing Medical Care
_____ Mental Health Records (Except Psychotherapy Notes)	□ Personal Use
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)	□ Billing or Claims
_____ Genetic Information (Including Genetic Test Results)	□ Insurance
	□ Legal Purposes
	□ Disability Determination
	□ School
	□ Employment

	□ Other *(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

NOTICE: This sample **Authorization to Use or Disclose Protected Health Information** was prepared by the Texas- based law firm of Jackson Walker, L.L.P. Any questions regarding this material are subject to the following paragraph and should be directed to your own legal counsel or to Jeffery Drummond at (214) 953-5781. The Texas Medical Association (TMA) has no responsibility for the content of this material and makes no representation regarding the accuracy, currency, or completeness of this information.

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