AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____

Contact Phone: _____

RELEASE MY INFORMATION:

FROM:

_____

_____

_____

_____

TO:

☐ Dr. Calley Asbill, ND ☐Kellie Chambers, LAc ☐Dr. Lori Carroll, DC

☐ Sarah Reynolds-Jackson, LMT ☐Joel Amezcua, LAc ☐Dr. Jenna Hamza, ND

Elixir: A Wellness Collective
2146 NE 4th Street #160
Bend, OR 97701

REASON FOR DISCLOSURE:

☐ Treatment/Continuation of Care ☐ Insurance ☐ Personal Use ☐ Legal Purposes ☐ Other

WHAT INFORMATION CAN BE DISCLOSED? Indicate the items that you want disclosed. If all health information is to be released then select only the first item.

☐ Lab Results ☐ Imaging Results ☐Chart Notes ☐Intake Form/Initial Visit Chart

DATE RANGE: From _____ to _____

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING INFORMATION:

____Mental Health Records ____ Substance Abuse Records ____Genetic Information ____HIV/AIDS Results/Treatment

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 is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): ___/___/_____.

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 re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

_____ _____

GUARDIAN NAME (IF APPLICABLE) **RELATIONSHIP TO PATIENT**