20 Roche Brothers Way Unit 6, #332North Easton, MA 02356

294 Pleasant Dr., STE 105Stoughton, MA 02072Phone: (7 74) 227-8482, ext 802

## Authorization to Use or Disclose My Health Information

Patient name: ____________________ Previous name if used:____________________

Date of birth: ____________________

## I My Authorization

**You may use or disclose the following health care information (check all that apply):**

☐ All my health information maintained by the above-named practice *(Circle "include" or "exclude" for each of the following)*

☐ Include ☐ Exclude My health information related to drug abuse

☐ Include ☐ Exclude My health information related to alcohol abuse My health information

☐ Include ☐ Exclude related to HIV/AIDS

☐ Include ☐ Exclude My health information related to psychological or psychiatric conditions, including psychotherapy notes

☐ My health information relating to the following treatment or condition: ____________________

______________________________________________________________________

## II Disclosure **You may disclose this health information to:**

Name (or title) and organization:

Address:

## III Reason(s) for this authorization (check all that apply):

☐ At my Request ☐ One time only when the following event occurs on

☐ While under care of Healthier Body Institute.

***Unless otherwise stipulated, this authorization ends one year from date of signature or while under the care of Healthier Body Institute.***

## IV My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study OR
- To receive health care when the purpose is to create health information for a

third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office. OR
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

__________________________________________ ________________________
Patient or legally authorized individual signature Date

__________________________________________
Printed name if signed on behalf of the patient Date ________________________

Relationship (parent, legal guardian,
personal representative, etc.)