Everhope Clinic PLLC
Naturopathic Medicine

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926 Main Street #14
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AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

Individual Information

Patient Name: _____ SSN: _____ - _____ - _____ Date of Birth: ___ / ___ / ___

Everhope Clinic PLLC may receive information about me from:

Name of provider or organization releasing information: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

I authorize Everhope Clinic PLLC to disclose information about me to:

Name of provider or organization to receive information: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____

What kind of information do you want disclosed? (Fees may apply.)

___ All records from the last 2 years of visits.
___ All information from date ___ / ___ / ___ to date ___ / ___ / ___
___ All labs from date ___ / ___ / ___ to date ___ / ___ / ___
___ All imaging from date ___ / ___ / ___ to date ___ / ___ / ___
___ Other (include dates): _____

Why are you asking for this health information to be released? (Check **one**.)

___ Attorney ___ Insurance ___ Physician ___ Medical Leave ___ Personal ___ Other _____

Terms and Conditions of Release

- You have the right to revoke this authorization by doing so in writing and submitting your request to Everhope Clinic, PLLC. Your revocation will not apply to information that has already been disclosed in reliance on this authorization.
- Authorizing the use of disclosure of information identified above is voluntary, and I need not sign this form to obtain healthcare treatment.
- Once the information is disclosed, it may be subject to re-disclosure by the recipient, and federal privacy laws or regulations may no longer protect the information.
- I release Everhope Clinic, PLLC from liability and claims of any nature pertaining to the disclosure of requested protected health information pursuant to this authorization.
- This authorization expires 90 days from the date signed or on the following date _____.

Signature: _____ Date: _____

Relation to Patient: ___ Parent ___ Guardian ___ Spouse ___ Personal Representative ___ ID Verified