

## Authorization to Disclose Protected Health Information To The Natural Family Health Clinic, LLC

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
DOB: \_\_\_\_\_ Address: \_\_\_\_\_

I hereby authorize The Natural Family Health Clinic, LLC to obtain my medical information from:  
Physician/Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

By INITIALING the spaces below, I authorize release of the following records:

\_\_\_\_\_ Entire Medical Record \_\_\_\_\_ Radiology  
\_\_\_\_\_ Laboratory Report (specify): \_\_\_\_\_  
\_\_\_\_\_ Operative Report \_\_\_\_\_ Other (specify): \_\_\_\_\_  
\_\_\_\_\_ Pathology Report

The following items must be initialed to be included in other documents:

\_\_\_\_\_ HIV/AIDS Related Record \_\_\_\_\_ Mental Health Record  
\_\_\_\_\_ Drug/Alcohol Diagnosis, Treatment or Referral Information  
\_\_\_\_\_ Genetic Testing Information

(Federal regulation requires a description of how much information and what kind of information is to be disclosed)

Describe: \_\_\_\_\_

For the specific purpose of:

This authorization will expire 180 days from the day of signing.

As required by the Privacy Regulations, The Natural Family Health Clinic, LLC may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. I understand that the information disclosed above may be re-disclosed to additional parties and may no longer be protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document; it will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits; whether or not I provide authorization to use or disclose protected patient health information.

Signature: \_\_\_\_\_  
Patient or Authorized Representative Relationship Date (mm/dd/yy)