HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

THE CENTER FOR MEDICAL HEALING, DR. ANNETTE DA SILVA, ITS AFFILIATES, ITS EMPLOYEES AND AGENTS COLLECTIVELY,

RE: Patient Name: ____ Date of Birth: _________________
Social Security Number: _____________________

I authorize and request the disclosure of all protected information relating to the diagnosis, treatment, claims payments and health care services provided or to be provided to me which identifies my name, address, social security number, Member ID number. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, and records received by other medical providers. All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This protected health information is disclosed for the following purposes: FOR HELPING ME TO RESOLVE CLAIMS AND HEALTH BENEFIT COVERAGE ISSUES. I understand that any person health information or other information released to the person or organization identified above maybe no subject to re-disclosure and may no longer be protected by application state privacy laws. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand the following: See CFR §164.508(c)(2) (i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until withdrawn in writing at which time this authorization expires.

Signature of Patient or Legally Authorized Representative Date (See 45CFR § 164.508(c)(1)(vi))

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Name and Relationship of Legally Authorized Representative to Patient (See 45CFR §164.508(c)(1)(iv))

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Dated: ___________________________________