

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

TO: _____ (Provider)

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Privacy Rule, 45 CFR § 164.508, I authorize the "Provider" named above to release and disclose to **Dr. Lena Edwards and LDE, MD, PLLC d/b/a Balance Health & Wellness Center** or any of their representatives ("Facility"), any and ***ALL medical records and health information*** which you have concerning me. The purpose of this authorization and request is for the provision of health care and treatment of me by Facility. A photo-static copy of my medical records and health information for which I am authorizing disclosure shall be as valid as the original. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and substance abuse.

I understand that I have the right to revoke this authorization at any time, provided I do so in writing and present my written revocation to the privacy officer for the above-named Provider. I understand that my revocation will not apply to information already released in response to this Authorization, or to my health insurance carrier (if applicable) when the carrier has the right by law to contest a claim made under my certificate of coverage. Unless otherwise revoked, this Authorization will expire one (1) year from the date of my signature below.

I further understand that authorizing disclosure of my health information is voluntary and that I may refuse to sign this Authorization. I also understand that my health care providers may not condition treatment or payment on whether I execute this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in 42 CFR § 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the privacy officer for the Facility to whom I have Authorized the disclosure herein.

I further understand that treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party, or that is research related treatment, on my signing this Authorization.

DATE OF SIGNATURE

PATIENT SIGNATURE

PRINTED NAME

SSN: _____

DOB: _____

COMMONWEALTH OF KENTUCKY
COUNTY OF _____ A

SUBSCRIBED AND SWORN to AND ACKNOWLEDGED before me by the above-named PATIENT, this _____ day of _____, 20____.

My Commission Expires: _____

NOTARY PUBLIC, STATE AT LARGE, KENTUCKY
KY Notary ID# _____

