The Waterford Wellness Spa's Notice of Privacy Practices

Authorization for Release of Information

Patient Name _____ Date of Birth _____

This Notice provides information about how we may use and disclose your Protected Health Information and describes your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your Protected Health Information is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of your Protected Health Information for treatment, payment, and health care operations. You have the right to revoke this consent in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosure will then cease.
- The practice may condition treatment upon the execution of this consent.

I hereby authorize Lisa Curry APRN-BC and/or administrative and clinical staff to disclose Protected Health Information to the person(s) listed below:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Information to be released:

____ Any information regarding treatment or laboratory testing at the Waterford Wellness Spa

____ ONLY the information described as follows _____

This Protected Health Information is to be disclosed for the following purposes:

____ Family member or loved one's participation in health care

____ The following purpose(s) _____

_____

Signature of Patient/Legal Representative Relationship to Patient Date

_____

Signature of Witness Date