AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize use or disclosure of my protected health information as described below:

PATIENT NAME_____ DATE: _____

DAY PHONE: _____BIRTHDATE: _____SS#_____

APPROXIMATE DATE OF TREATMENT: FROM_____ TO: _____

_ _

FROM: THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE:

NAME OF DOCTOR OR HOSPITAL

ADDRESS

CITY STATE ZIP

PLEASE CHECK OFF THE ITEMS REQUESTED:

- ☐ All clinic records
- ☐ Imaging reports
- ☐ Imaging CDs
- ☐ Only these specific dates are needed_____ to _____
- ☐ Lab Results
- ☐ Other _____

This information is being sent at my request:

- ☐ Please fax my records to: **Head to Toe Holistic Healthcare** Fax #: **(907) 222-6877**
- ☐ Please mail my records at the address listed below:

TO: This information may be disclosed to and used by the following individual or organization:

NAME OF DOCTOR OR MEDICAL FACILITY:

Head to Toe Holistic Healthcare
121 W. Fireweed Ln. Suite 100
Anchorage, AK 99503

A. I understand that under HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearinghouse that is involved with your insurance claims fulfillment.
B. I understand that I may revoke this authorization at any time by giving written notice to your Privacy Officer.

_____ _____
Signature of Patient/Legal Representative Expiration Date of Authorization (Not more than 6 months after date of signing)

_____
Relationship if other than patient

Head To Toe Holistic Healthcare
121 W Fireweed Ln, Suite 100, Anchorage, AK, 99503
HeadToToeAK@gmail.com
(907) 222-6887 (907) 222-6877