*RUTLAND NATUROPATHIC, PLLC*
26 West St | Rutland, VT 05701 | (p) 802-776-4901 | (f) 802-488-5716

## HIPAA AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

**My Authorization**

I authorize the following using or disclosing parties:

☐ - Laurel Erath, ND

☐ - Greg Burkland, ND

☐ - Facility/ Doctor _____
City, State: _____
Phone:_____
Fax: _____

_____

**to use or disclose the following health information. (check all that apply)**

☐ - All of my health information

☐ - X-rays/ Radiographic Images

☐ - Labs/ Reports

☐ - Other _____

**The purpose of this authorization is at my request for the purpose of:**

☐ - Concurrent Care ☐ - Transfer of Care ☐ - Other_____

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. **Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (check the accompanying box(s) below to EXCLUDE the information from authorization)**

❍ substance abuse ❍ mental health/psychotherapy notes ❍ sexually transmitted diseases and ❍ HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call (802) 776-4901 to inquire about revoking this authorization.

_____
Patient or Guardian/ Personal Representatives Name (PRINT)

_____
Patient or Guardian/ Personal Representative's Signature

_____
Date