AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT NAME: _____ DOB: _____

Previous Name (if applicable):_____Social Security #: _____

I request and authorize_____to release healthcare information for the patient named above to:

Name: **Prototype Health**

Address: **Info@PrototypeHeal.com**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other:_____

This request is for the purpose of:

☐ Treatment/Continuing Medical Care

☐ Billing or Claims

☐ Insurance

☐ Other: _____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):
Month_____Day_____Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____

Patient Signature Date