We Care Advocates™

A division of Halo Health International, Inc.

HIPAA RELEASE FORM

Date:

Name of Client: _____ Date of Birth:

Email: _____ Phone: _____

I authorize any health care professional, or other health care provider that has provided treatment or services to me within the past 2 years to disclose my entire medical records, and any other protected health information concerning me to any representative of **We Care Advocates**.

By my signature or my representative's signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any health care professional, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization that representative of We Care Advocates may obtain the necessary information (written or verbal) to assist me.

This authorization shall remain in force for twenty-four (24) months following the date of my signature below, and a copy of this authorization is a valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to **We Care Advocates.**

I understand that a revocation is not effective to the extent that any of my providers have already relied on this authorization to disclose information about me. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentially of health information, but it will not be disclosed by any representative of **We Care Advocates**, except as authorized by me or my representative, or as required by law.

I understand that if I refuse to sign this authorization, **We Care Advocates** may not be able to help. I understand that I, or my authorized representative will receive a copy of this authorization upon request.

- Signature of Client or Client's Personal Representative: _____
- Printed Name of Client or Client's Personal Representative: _____
- Signature of We Care Advocate Representative: _____
- Printed Name of We Care Advocate Representative: _____

Submit