WWW.FUNCTIONALROOTGENICS.COM
HOLISTIC NUTRITION AND WELLNESS

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I am very concerned with protecting your privacy. While the law requires that you give me this disclosure, please understand that I have, and always will, respect the privacy of your health information.

There are several circumstances in which I may have to use or disclose your health information:

- I may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- I may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.
- I may need to use your health information within my practice for quality control or other operational purposes.

I authorize Functional Rootgenics, LLC to contact me with information related to my personal health needs and interests. Functional Rootgenics, LLC may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my voicemail service. I may be contacted about following:

- Appointment reminders
- Information about alternative treatments, presentations, or events
- Other health related information that may be of interest to me

To contact me, I authorize Functional Rootgenics, LLC to use and disclose the following information:

- My name, address, email and phone number
- The name of my physician and the clinic where I was treated

NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.

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Patient Name:

Date of Birth:

Street:

City:

State, zip code:

Phone:

Email:

Functional Rootgenics, LLC fully supports the protection of health information. Only I will use this information to contact you. While I retain the standard rights of disclosure as provided under HIPAA, this authorization allows me to access only the above authorized information for contact purposes.

This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time. In the case, every effort will be made to discontinue future communications.

Signature _____ Date_____