



**RELEASE OF INFORMATION AUTHORIZATION**

I, \_\_\_\_\_, DOB \_\_\_\_\_, authorize the release of my medical records to Triton Wellness Solutions & SoftWave Therapy.

Information Authorized for Release (check Yes or No):

- Yes  No Medical records including physical and mental health history and treatment.
- Yes  No Diagnostic and therapeutic records including test results, consultations, inpatient/outpatient records, notes, and orders.
- Yes  No Sensitive records, including HIV/AIDS-related information and substance use disorder treatment records, if applicable.

Purpose: Coordination and continuity of care between the releasing provider and Triton Wellness Solutions & SoftWave Therapy.

Authorization & Rights: I understand this authorization is voluntary and may be revoked in writing at any time, except to the extent action has already been taken in reliance on it. Refusal to sign will not affect treatment, payment, or eligibility for benefits, but may limit coordination of care. I understand information disclosed may be re-disclosed and may no longer be protected under HIPAA, Idaho law, or 42 CFR Part 2.

Expiration: This authorization expires one (1) year from the date signed, unless otherwise specified in writing.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

If applicable: Personal Representative Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_

Send records to: Triton Wellness Solutions & SoftWave Therapy