AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services and the Annotated Code of Maryland, Title 10 Health General Article § 4-301 – 4-307. All items on this authorization must be completed in full.

Print Name of Patient:_____ **Date of Birth**: _____

I hereby authorize Key Vitality solutions, LLC (Address): 8114 Sandpiper Circle Suite 108 Nottingham, MD 21236 (Phone): 443-725-7747 (Fax): 833-974-2182

To: **Circle One:** Receive or Disclose my health information.

☐ All Health Information ☐ History & physical exam ☐ Other_____

☐ Diagnostic reports ☐ Consultation reports ☐ Period from_____

☐ Laboratory reports ☐ Reports of operations to_____

☐ Discharge summary ☐ Pathology reports

The purpose for such disclosure is: (check all that apply):

☐ Payment / Treatment ☐ At my request (only patient may check) ☐ Other: _____

I hereby authorize the party listed below to: **Circle One:** Receive or Disclose my health information

Name of organization: _____

Address: _____

Phone: _____ Fax: _____

This authorization will expire one year from the date it is signed

I understand I have the right to revoke this authorization at any time in writing, except when uses or disclosures have already been made upon my original permission. I understand that this authorization is voluntary, and I may receive a copy of this form.

Patient or Authorized Representative's Signature: _____

If signature is other than patient, explain your authority to act on the patient's behalf:

_____

Authorized Representative's Name (Please Print): _____

Date _____