BEWELLMY*FRIEND*, LLC
Integrative Health Center

Authorization for Release of Protected Health Information (PHI)

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

I hereby authorize (name of facility/provider **releasing** information) **to disclose the above-named individual's health information:**

Facility Name (releasing information): _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Facility Telephone Number: _____ **Facility Fax Number:** _____

Date(s) of Service Requested (if known) or Provider: _____

Description of Information to be released: (check all that apply)

___Progress notes ___Consultations ___Most recent history and physical

___Prescriptions List ___Laboratory reports ___Radiology films

___Radiology/Imaging reports ___Immunization record

___Two-way verbal exchange of communication ___Other_____

_X_ Entire medical record (to include all previous provider's records)

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed <u>to</u> and used by the following individual or organization (receiving the information)

Facility Name (facility receiving information): BE WELL MY FRIEND LLC

Address: 12 Shuman Ave. Ste 6 City: Augusta State: ME Zip: 04330

Facility Telephone Number: (207) 307-0958 Facility Fax Number: (207) 512-5909

Description of the purpose of the use and/or disclosure: (check one)

___Continuing Care ___Second Opinion ___Emergency/acute care

___Consultation ___Legal purposes ___ Personal Use

_X__ Other: Transfer of medical care

I understand that this authorization is voluntary and I may refuse to sign this authorization. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. This authorization will expire by 12 months from the date of this authorization unless I otherwise specify.

I further understand that I may revoke this authorization at any time. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
(Printed name of Patient or Patient's Representative) (Relationship to Patient or Legal Authority)