Authorization for Disclosure of Health Information

I hereby authorize_____ to disclose personal healthcare information.
Patient Full Name: _____DOB: _____
Social Security Number: xxx-xx-_____Phone Number : _____
Address: _____
Protected Health Information to be released:

- Complete medical record
- History and Physical
- Lab Result
- Progress Note
- Radiology Report
- Consultation Report

Dates of Service Requested:_____ to _____

I authorize the release of personal healthcare information to Herb Medical Consulting, LLC for the purpose of evaluation, treatment, payment, and/or healthcare operations unless otherwise specified.

Preferred Form/Format:

- Paper: Mailed to Post Office Box 1589, Saltillo, Mississippi 38866
- Secure E-mail: records@nemsherbal.com
- Fax: (662) 601-2298

Designated Record Recipient: [ ] Self or [ ] Authorized Representative

HERB Medical Consulting
Post Office Box 1589
Saltillo, Mississippi 38866
Phone (662) 372-5308
Fax (662)601-2298

This consent will expire one year from the date of signing unless otherwise stated here:

_____

I understand that I am authorizing the release of protected health information to Herb Medical Consulting, LLC for the purpose of evaluation and treatment.

Patient Signature	Date

E-mail: records@nemsherbal.com
Physical Address: 2785 Highway 145, Saltillo, Mississippi 38866
For questions or concerns please contact our office at (662) 372-5308.