HIPAA Release of Information Authorization

Patient's Legal Name: _____
Date of Birth (MM/DD/YYYY): _____

I, the undersigned patient (or legal representative), hereby authorize iTrust Wellness Group, LLC, including its healthcare providers and staff, to disclose and exchange my protected health information (PHI) with the following individuals and/or organizations:

Name: _____
Relationship/Organization: _____
Address: _____
_____
Email Address: _____
Phone Number: _____ Fax Number: _____

Name: _____
Relationship/Organization: _____
Address: _____
_____
Email Address: _____
Phone Number: _____ Fax Number: _____

Name: _____
Relationship/Organization: _____
Address: _____
_____
Email Address: _____
Phone Number: _____ Fax Number: _____

Scope of Information: I authorize the release of all relevant and necessary medical and psychiatric information, including but not limited to, diagnoses, treatment plans, medication information, laboratory results, and progress notes. This information will be used solely for the purpose of providing coordinated and appropriate care.

Duration of Authorization: This authorization shall remain in effect until otherwise revoked by me in writing. I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken based on this authorization.

_____
Patient (or Legal Representative) – Print or Type Name

_____ _____
Patient (or Legal Representative) – Write or Type Signature Date Signed