Elevate Functional Medicine & Anti-Aging Center
470-266-1380 ph
Release of Information

AUTHORIZATION FOR USE OR EXCHANGE OF PHI

Completing this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this Authorization.

Client Name: _____ Date of Birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ and their employees and agents (individually, and collectively, the "Company") to release verbally, by mail, fax or unencrypted email, the protected health information described below to the following person or organization at the following address:

I understand that the Company may charge me a reasonable fee for copying the information in accordance with applicable state law.

PURPOSE of Disclosure: The purpose of the requested use or disclosure is as follows (check applicable categories):
□ Patient Request
□ Service Provider Request (reason: _____)
□ Other (specify: _____)

Information to Be Used or Exchanged:
□ All health information pertaining to my medical history, mental or physical condition and treatment received; or

□ Only the specific records or types of information checked below:
□ Office Visits _____ to _____ (dates)
□ Lab Results _____ to _____ (dates)
□ Diagnosis
□ Medication History/Current Medications
□ Results of Psychological Tests
□ Other (Specify: _____)

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□ Release of information requiring specific consent. The following categories of information may be included in your medical record, and WILL NOT be released unless you indicate your specific authorization by INITIALING each appropriate category.

	Abortion		Genetic Testing
	Alcohol/Drug Abuse		HIV/ADIS Results/Treatment
	Behavioral/Mental Health		Rape/Sexual Assault
	Domestic Violence		Sexually Transmitted Diseases

Expiration Date of Authorization: This authorization automatically expires 90 days from the date set forth below unless otherwise specified:

_____.

Your Rights With Respect to This Authorization: I understand that I have the following rights:

- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, or payment, or eligibility for benefits unless: (i) my treatment is related to research and then I will not be permitted to have treatment without signing this Authorization or (ii) if/when I am receiving health care solely for the purpose of creating information for disclosure to a third party and then I may not receive care unless I sign the Authorization.

- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

- I have a right to receive a copy of this Authorization and if I sign it I have a right to a copy of the document I signed.

- I may revoke this Authorization at any time by notifying Company's Privacy Official in writing and delivering a copy in person or mail or fax it to:

Elevate Functional Medicine & Anti-Aging Center
Attn.: Privacy Official 4485 Tench Rd Suite 740, Suwanee, GA 30024

This Authorization will be revoked effective upon receipt of such written revocation by Company's Privacy Official. A copy of this signed, dated Authorization shall be as effective as the original.

I understand that the information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and might no longer be protected by HIPAA.

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The undersigned does hereby release, hold harmless and agree to indemnify Company, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until Company is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that the Company has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization.

Signature	
Name (First, Last)	
Name and capacity to sign if other than client (i.e., parent or guardian)	
Address	
Home phone	
Cell phone	
Email	
Date	