

AUNT MARTHA'S HEALTH & WELLNESS
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
AND/OR BILLING RECORDS

I hereby authorize Aunt Martha's Health and Wellness Inc.'s ("Aunt Martha's") to use and/or disclose the protected health information ("PHI") and/or billing records as described below to:

Records Deposition Service, P.O. Box 5054, Southfield, MI 48086-5054

[Name, Title, and Contact Information of Recipient of Information]. F (248) 357-3337
E requests@recdep.com

I voluntarily consent that information concerning the care of the below-named individual may be used or disclosed. I affirm that I am either the named individual, or if the named individual is under the age of eighteen (18) years old, I am the legal guardian.

Full Name: _____

Date of Birth: _____ **Phone Number:** _____

Street Address: _____

Information to be Disclosed:

Date Range of Requested Records: _____

PHI that may be used and/or disclosed includes (check all that apply):

- | | |
|---|--|
| ☐ Full and complete record with billing records | ☐ Diagnostic Test Results |
| ☐ Full and complete record without billing records | ☐ Illinois School Forms |
| ☐ Assessment/Treatment plan | ☐ Intake Documentation |
| ☐ Billing Records | ☐ Medications/Prescriptions |
| ☐ Consultations | ☐ Patient/Provider Correspondence |
| ☐ Dates of service | ☐ Physical |
| ☐ Discharge summary | ☐ Physicians Orders |
| ☐ Diagnosis | ☐ Referral Records |
| | ☐ Vaccination History |

If the information to be disclosed contain any of the below, you must specifically authorize the release of information below by checking those that apply:

- ☐ Information related to mental health or developmental disabilities
- ☐ Psychotherapy notes
- ☐ Information related to genetic testing and information derived from genetic testing
- ☐ Information related to alcohol/substance abuse
- ☐ Information related to HIV/AIDS/Sexually Transmitted Infections
- ☐ Other (specify): _____

It is my full understanding that if indicated above, the records to be disclosed WILL include sensitive information such as evaluation, treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDS/Sexually Transmitted Infections.

Purpose of Disclosure. I understand that the PHI may be used and/or disclosed by Aunt Martha's for the purpose of complying with subpoenas or records request for the named individual's records as required by law or to facilitate requested care and treatment.

Individual Rights. I understand that I have the right to refuse to sign this authorization. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form. Furthermore, I understand that I have the right to inspect or obtain a copy of the disclosed information.

This authorization is valid until the following date or event: _____.
If I fail to specify an expiration date or event this authorization will expire one year from date of signature.

I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that Aunt Martha's has acted in reliance upon it, by sending written notification to Aunt Martha's. Revocation will not apply to any information already disclosed based on this authorization. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

I understand that the recipient of PHI disclosed pursuant to this authorization has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

Signature. I have read and understand this form. I authorize the release of personal health information as described above.

Individual/Guardian Signature: _____

Individual/Guardian Printed Name: _____

Date: _____

Witness Signature (if applicable): _____

Witness Printed Name: _____

Date: _____