HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient/Client name:_____DOB:_____

I, _____,hereby authorize release of my medical health records including:

☐ all records for my evaluation, care and treatment including drug information____; emergency room records; nursing notes; laboratory results (individually copied); pathology reports; and x-ray reports, HIV testing_____; psychiatric records_____; abortion records_____.

☐ laboratory test results ☐ pathology reports ☐ x-ray reports

For the dates of _____ to _____.

I understand that:

- My health information may include general information related to my psychiatric health, drug/alcohol abuse, communicable diseases, abortion or other information I may consider sensitive.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the sole purpose of treatment is to provide information to a third part. I may inspect or copy any information used/disclosed under this authorization and understand there may be a fee for copying my health information.
- This authorization is valid unless and until it is revoked, in writing, and properly presented to the records office of Anna Abele, ND.
- If the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations and do not hold Anna Abele, ND legally liable for such redisclosure.
- I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

Please release this information:

FROM / TO the offices of:
(Please circle "From" or "To" above)

Dr. Anna Abele, ND at

A Natural Path

1037 Western Ave Suite 1 Brattleboro, VT 05301

376 Pleasant Street Northampton, MA 01060

Fax: 802-275-5221 (ph: 802-275-5223)

FROM / TO the offices of:
(Please circle "From" or "To" above)

Dr._____

_____

_____

_____

_____

The information will be used/disclosed for the following purposes:

☐ continuing medical care ☐ other: _____

_____Email communication of above information authorized *(understanding that the transmission of information over the internet is not always secure)*
(initials)

_____ **Date**_____

Signature of Patient (or his/her authorized representative, or parent or guardian)

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Please specify relationship to patient/client if a minor: _____

The authorization expires one year from date signed unless otherwise specified.

updated April 2012