Unity Health & Wellness, LLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name_____

DOB _____ Phone number _____

1. **Entity who is authorized to release Patient's information: (*Unity Health & Wellness or entity in ownership of records*)**

   Name _____ Fax _____Phone _____

2. **Entity(ies) to whom the Patient's information may be disclosed (Where the records will be going.)**

   Name _____

   Address_____

   Phone _____ Fax _____

3. **The specific information that should be disclosed:**

   _____ LAST 24 MONTHS OFFICE NOTES/LABS/X-RAYS _____ LAST 12 MONTHS OFFICE NOTES/LABS/X-RAYS

   OTHER (BE SPECIFIC):

   _____

   Pick up_____ Where?_____ Faxed_____ Mailed_____

4. **The purpose for the disclosure is:** _____

5. **This authorization will expire on the following date or event:** _____

   If no expiration date or event is listed, the authorization will expire one year after the date of the authorization.

   WE PROVIDE THE PAST TWO YEARS OF RECORDS TO OTHER PROVIDERS (with a note to call if they need more) IF A PATIENT WANTS ARCHIVED RECORDS SENT TO THEMSELVES OR ANOTHER PROVIDER, THERE WILL BE COPYING FEES APPLIED AS FOLLOWS: (1-50 PAGES $15, 51-100 PAGES $25, OVER 100 PAGES $40) *All records given directly to patients will be copied to a disc*. Pre-payment is required.

   Signed:

   _____ Date_____
   Patient

   _____ Authority_____
   Personal Representative (parent, guardian, etc.)