

PATIENT'S NAME: _____ HR#: _____ DATE: _____

HIPAA Personal Health Information Release Authorization

I, _____, hereby authorize Pennridge Wellness Center to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- Spouse Name: _____
- Significant Other Name: _____
- Parent/Legal Guardian Name: _____
- Child(ren) Name(s): _____
- Any Specified Person Name: _____
- Information is not to be discussed with or released to anyone.

Restrictions:

- No Restrictions
- Only discuss my appointment time with the above-named individual(s).
- Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call my home my work my cell phone

Phone Number: _____ - _____ - _____

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- _____

I understand I may terminate this consent at any time by giving written notice to Pennridge Wellness Center. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____