HIPPA Authorization form

Lehigh Valley Wellness Center

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize the staff of **Lehigh Valley Wellness Center** to use and/or disclose certain protected health information (PHI) about me to individuals/facilities, health care insurance companies involved with my health care

This authorization permits **Lehigh Valley Wellness Center** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one year from the date signed and will need to be renewed annually.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI except by the health care insurance companies for the purposes of payment of services rendered to you for your care.

I do not have to sign this authorization in order to receive treatment from **Lehigh Valley Wellness Center**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: **Lehigh Valley Wellness Center at 210 Prospect Avenue, Lower Level, Phillipsburg, NJ 08865**

Signed by: ______________________________ ____________________

Signature of Patient or Legal Guardian **Relationship to Patient**

______________________________ ____________________

Print Patient's Name **Date**

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Print Name of Patient or Legal Guardian, if applicable