PHUSION WELLNESS

AUTHORIZATION FOR USE/DISCLOSURE OF
HEALTH INFORMATION

Patient Name:_____Patient Address:_____

Patient Phone: _____DOB:_____

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider
Name of Facility_____ Address: _____
Phone Number:_____Fax Number:_____

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: Phusion Wellness
Address: 1148 W Baseline Rd. Mesa, AZ 85210
Phone: 480-559- 3149
Fax: (855) 822-6349
Email: info@phusionwellness.com
Purpose: I authorize the release of my health information for the following specific purpose: Phusion Wellness to opioid therapy.

Information to be disclosed:
I authorize the release of the following health information: (check the applicable box below)

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me. Only the following records or types of health information:

_____

_____

PHUSION WELLNESS

Term: I understand that this Authorization will remain in effect:

From the date of this Authorization until the _____ day of _____, 20___.

Until the Provider fulfills this request.

Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

1 NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

Refusal to sign/right to revoke:

I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Phusion Wellness. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Phusion Wellness. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact Phusion Wellness at 1148 W Baseline Rd. Mesa, AZ 85210

Signature _____ Date_____

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian Legal Relationship _____ Date_____