Well Nourished LLC
Integrative Psychiatry
Wellnourishedpsych.com

Phone: (720) 513-1215
Fax: (720) 547-6960
Address: 12157 W Cedar Dr. Suite 200 Lakewood, CO 80228

Medical Records Request

Patient Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164).

Effective Date: _______________

Patient Name: ____
Patient Address: ______________________________________
Patient DOB: ___________
Patient Phone: _______________________________________

Authorization. I _________________(Patient name) authorize ________________________(health care provider) to use and disclose the protected health information described below to Well Nourished LLC.

Please fax the requested medical records to Well Nourished LLC at (720) 547-6960 or email them in a secure, HIPAA-compliant manner to HIPAA secure email office@wellnourishedpsych.com

Effective Period. This authorization for release of information covers records pertaining to all past, present, and future periods of health care in any and all formats or portions.

Purpose of requested use or disclosure: Patient request.

This authorization will remain in effect until the termination of care at Well Nourished LLC. I understand that I have the right to revoke this authorization, in writing, at any time, except where uses and disclosures have already been made based upon my original consent. I agree that revocation must be communicated in writing to Well Nourished LLC..

I understand that authorizing the disclosure of this information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria. I understand I am entitled to a copy of this document in its complete form. I understand that it is possible that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Name (printed) ____
Patient Signature: __________________________________
Date:______________________________________