AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I _____(pt name) _____(DOB) voluntarily consent to an authorize my health

Provider: _____ _____ _____
provider name phone number fax number
to disclose my health information.

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

SHEKINAH HEALTH AND WELLNESS CENTER
325 CLYDE MORRIS BLVD, SUITE 430
ORMOND BEACH, FL 32174
P: 386-206-2929 F: 386-951-3312
totalcare@shekinahealth.com

Purpose: I authorize the release of my health information for the following specific purpose:

_____

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.

---------- HIV test results ---------- outpatient psychotherapy notes ---------- drug or alcohol treatment records ---------mental health records that are protected by the Lanterman-PetrisShort Act (initial for items protected by federal law)

□ Only the following records or types of health information:
_____.

Term: I understand that this Authorization may be revoked at any time by the patient.

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.

_____ _____ _____
Signature Date Signature of Witness

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

_____ _____ _____
Name of Guardian/ Representative Legal Relationship Date

_____
Witness