HIPAA Compliance
Authorization to Release Information

Patient consent to the use and disclosure of private health information for the treatment, payment and/or healthcare operations.

I, _____ , understand that as part of my healthcare, Seaside Wellness, LLC originates and maintains paper, and/or electronic records describing my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify services billed were provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Should it become necessary to disclose my protected information to another entity for the above purposes, I consent to such disclosure for these permitted uses, in disclosure, via fax.

On occasion, we may have confident health information, such as laboratory, or x-ray results, which we may wish to convey to you by telephone. Please indicate how you would like us to handle this. Please check all that apply:

____ Write only. Do not call

____ Call this number (_____) - _____- _____ to leave all health related information.

____ Detailed messages □ may □ may not be left at this number if answered by a voicemail message/machine.

____ Seaside Wellness, LLC may contact me by email. My email is: _____

____ My confidential health information may be discussed with the following people:

1. _____ 2. _____

***This will be filed in your medical record.*

_____ _____ /_____ / _____

Patient's Signature Date