PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:______________________________ Birth Date:______________ Maiden/previous/other names: ________________
(Please print) (Please print)

THIS WILL AUTHORIZE: ____(Name of person/ organization)
____(Address)

TO RELEASE INFORMATION TO: Bella Wellness & Aesthetics (Name of person or organization)
1201 Park Dr Ste 101 Hickman NE 68372 (Address)

INFORMATION REGARDING: (Circle all that apply)

All medical records Operative reports History & Physical Lab reports

Treatment plan Consultations X-ray reports Other:_________

PURPOSE OF RELEASE (CIRCLE ALL THAT APPLY):

Treatment/Referral Evaluation Insurance Purposes Personal Use Change of Provider

IF YOU ARE CHANGING PROVIDERS, PLEASE MARK THE REASON (CIRCLE ALL THAT APPLY):

Prefer different office location Problems with office staff Inadequate appointment availability
Moving out of town Prefer different provider Other ____________________

Bella Wellness & Aesthetics will not receive payment or other remuneration from a third party in exchange for using or disclosing this information. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization at any time by providing a written request to Bella Wellness & Aesthetics Privacy Officer, except to the extent that we have already acted in reliance **upon this authorization.**

I authorize the use and disclosure of the medical records and health care information indicated above (please print):

Signature: ________________________________ Print Name _____________
(Patient must sign if 19 years of age or over, otherwise parent, or legal representative)

Relationship to patient if not signed by patient: ____________________

Current address: ____
Street City State Zip

Current home phone:________________________ Current work phone:________________________

Today's date: _________________ This authorization will expire on: ______________________________
(Specify an expiration date or event)

PLEASE NOTE: THERE WILL BE A $.50 PER PAGE CHARGE FOR COPYING RECORDS FOR PERSONAL USE ($50 MAXIMUM)
THERE IS NO CHARGE FOR RECORDS SENT DIRECTLY TO ANOTHER MEDICAL FACILITY.
(NOTE: The person signing this authorization is entitled to a copy of this form. If the information being released is for a patient who is 19 years of age or over at the time of the request, the patient must sign this form.)