

**Authorization For Use of Disclosure of Protected Health Information
To Journey of Health Medical Clinic**



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As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California law, this practice may not use or disclose your individually identifiable information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the used and disclosures described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I, _____ (patient's name) hereby authorize this medical practice to use and disclose health information as described below.

Date of Birth: ___/___/___

Health information to be used or disclosed. (Check box of records requested)

Lab Results

Imaging Results

This health information may be disclosed to: **Dr. Shannyn Fowl, ND.**

This information may be used only for the purpose of: Treatment and Diagnosis

This authorization is in effect for 1 year from the date below unless otherwise dated here: _____.

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. I understand that I may refuse to sign this authorization and that my health care treatments or benefits will not be affected whether or not I sign this form. I understand that I have the right to receive a copy of this authorization.

Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse; under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Patient signature: _____ Date: _____

Relationship to patient (If signed by other):

Dr's. Name: _____ Address: _____

Phone Number: _____ Fax Number: _____