258 Hanging Rock Highway, Suite 3, Logan, WV 25601
Phone: 304-752-4594 Fax: 304-752-5629
www.healthyhabitswellness.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____

to release healthcare information of the patient named above to Healthy Habits Wellness Center.

This request and authorization applies to:

❑ Healthcare information relating to the following treatment, condition or dates:

❑ All healthcare information ❑ Other (Please list below)

_____

_____

1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
2. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address of the office where the records were requested.
3. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
4. I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the office where the records were requested.
5. I understand that a copy or FAX of this document is just as valid as the original document.
6. I understand that this authorization will expire 90 days after signed unless an earlier date is specified here _____.

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.