HIPAA Release of Information

1. I authorize ______________________________ (healthcare provider) to use and disclose the protected health information described below to Healthy Results, LLC (Dana Dameron, DO ABIM).

2. This authorization for release of information covers the period of healthcare from:
   - ☐ all past, present, and future periods. ****OR**** ☐ from ____________ to ____________.

3. I authorize the release of:
   - ☐ my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

   ****OR****

   - ☐ my complete health record with the exception of the following information:
   - ☐ Mental health records
   - ☐ Communicable diseases (including HIV and AIDS)
   - ☐ Alcohol/drug abuse treatment
   - ☐ Other (please specify): ________________________________.

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall remain in force and effect, and that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____________________________________ ____________________________________

Signature of patient or personal representative Date

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Printed Name