HIPAA Release of Information

Patient name:_____ Date of birth of patient:_____

1. I authorize Healthy Results, LLC (c/o of my previous provider Dana Dameron, DO ABIM) to release and disclose the protected health information described below to:
   Name:_____
   Address:_____
   Email:_____
   Fax:_____

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 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 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 Patient's **Date of Birth**

_____ _____

Printed Name **Date**

Once completed, email this form to dr.danadameron@gmail.com