



HUMMINGBIRD HEALTH & WELLNESS

1015 E Broad Street, Ste 112

Columbus, Ohio 43205

P: 614-285-6562

E: info@hummingbirdhealthohio.com

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Address _____ Phone Number: _____

Authorization

I hereby authorize Hummingbird Health & Wellness to: __ disclose __ request __ exchange my protected health information as described below, in accordance with applicable federal and state privacy laws, including HIPAA, with the following entity:

Name / Organization: _____

Address: _____

Phone: _____

Fax: _____

Information to Be Released

(Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Lab Tests |
| <input type="checkbox"/> Treatment summaries | <input type="checkbox"/> Last 3 treatment/progress notes |
| <input type="checkbox"/> Medication information | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Appointment and attendance records | <input type="checkbox"/> Other (please specify):
_____ |
| <input type="checkbox"/> Billing and insurance information | |

Purpose of Disclosure

(Please check one)

- | | |
|---|--|
| <input type="checkbox"/> Continuity of care | <input type="checkbox"/> Legal / administrative purposes |
| <input type="checkbox"/> Insurance / billing purposes | <input type="checkbox"/> Other:
_____ |
| <input type="checkbox"/> Disability | |

Expiration of Authorization

This authorization will expire on:

- _____ (specific date)
- One (1) year from the date of signature

Important Information

I understand that I may revoke this authorization at any time by providing written notice to [Practice Name], except to the extent that action has already been taken based on this authorization.

I understand that information disclosed under this authorization may no longer be protected by federal privacy laws once released to the recipient, unless otherwise required by law.

I understand that my treatment will not be conditioned on whether or not I sign this authorization.

Patient Name (Please Print)

Patient Signature

Date

If signed by a legal representative:

Name (Please Print)

Relationship to Patient