RECORDS REQUEST

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:								
	First	Middle In	itial	Last				
Birthdate:	Phone:							
Information to be re	leased from:							
Dr	Agency							
Street	(City	State	Zip				
Phone()		Fax ()					
Please mail or fax a copy of my records to:								
HIGHLAND SPRINGS WELLNESS CENTER								
1061 E. Main Stree	t, Suite 204							
Grass Valley, CA 95	5945	Phone: 530-2	74-2274	Fax: 530-274-2559				

As required by the Privacy Regulations, Highland Springs Wellness may not use or disclose my protected health information without my authorization except as provided in the Notice of Privacy Practices.

Purpose of Release: <u>X</u> C	consultation _	Patient Request		_Second Opinion
Information to be released:	All Records	Lab Results	X	_X-Ray <u>Reports</u>
	X Diagnosis	X Last Chart Note	es	

This authorization is valid for one year from the date of consent. I understand that I am entitled to a copy of this authorization upon request. This authorization may be revoked by me at any time in writing, and that revocation will not affect this office's previous reliance on the uses or disclosures pursuant to this authorization.

I understand that the information disclosed above might be re-disclosed to additional parties and no longer protected for reasons beyond the control of HSWC. I further release HSWC and its facility and employees from any liability arising from the release of information to the person/agency designated above.

I understand that I have the right to any knowledge of any remuneration involved due to any marketing activity as allowed by and as a result of this authorization. I understand that under federal law I have the right to inspect a copy of my health information being used or disclosed. I understand that I can restrict what is disclosed with this authorization.

I the undersigned authorize you to release any and all medical records in your possession, as indicated. Such records may include and/or contain reference to psychological information; drug, alcohol, and/or substance abuse history; sickle cell disease; and/or testing for HIV virus and/or AIDS.