HIPAA RELEASE FORM

RE:

Date of Birth
_____/_____/_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 30 years to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to any representative of Andrea M. Zaite, LLC. This also includes information on the diagnosis treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psycho- notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital , clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that representatives of Andrea M. Zaite, LLC may obtain the necessary information (written and verbal) to manage my medical care and assist my future treatment and living arrangements.

This authorization shall remain in force for 26 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Andrea M. Zaite, LLC

I understand that a revocation is not effective to the extent that any of my providers have already relied on this authorization to disclose information about me. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be disclosed by any representative of Andrea M. Zaite, LLC, except as authorized by me or as required by law.

I understand that if I refused to sign this authorization to release my complete medical record, Andrea M. Zaite, LLC may not be able to manage my care. I understand that any authorized representative or I will receive a copy of this authorization upon request.

____
Client's Printed Name

____ ____/____/____
Signature of Client or Client's personal representative Date

____ _________________________
Printed name of client's representative Relationship to Client