Nutrition Works, LLC
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The Covered Entity may not use or disclose your protected health information except for purposes of treatment, payment, health care operations or other reasons permitted by law. You must authorize any other use or disclosure of your protected health information.

Part 1. INDIVIDUAL'S INFORMATION			
Individual's Name:			
Home Street Address:		Date of Birth:	
City:	State:	Zip Code:	Phone Number:

Part 2. INFORMATION ABOUT THE USE or DISCLOSURE

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

I, the undersigned individual, hereby authorize the following Entity(ies) and its(their) business associates

Persons authorized to provide Protected Health Information:

____

____

____

to release to the person listed below all information, including medical records, relating to the medical, physical, behavioral and mental condition, treatment, claims, billing and expenses of the individual identified in Part 1, which are held by you. I also authorize the release of documents related to application or authorization for medical services, case management records, utilization management records, and care coordination documents.

Release my Protected Health Information to:

Name: ____ Phone Number: ____________

Address: ____

City:__________________________________ State: ________________ Zip Code: ____________

Purpose for Disclosure:

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_______HIV/AIDS information
_______Mental health information
_______Genetic testing information
_______Drug/alcohol diagnosis, treatment, or referral information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

Expiration Date of Authorization: __________ (indicate date, or an event relating to you or to the purpose of the authorization).

Part 3. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Part 4. SIGNATURE of INDIVIDUAL or IREPRESENTATIVE

I hereby authorize the Entity and its business associates to use or disclose my protected health information as described in Part 2.

______________________________ Signature of individual or legal representative	____________________ Date
______________________________ Printed name of individual’s legal representative, if applicable	____________________ Representative’s relationship to individual

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION