

HIPAA RELEASE AND AUTHORIZATION

Patient's Name: _____

Date of Birth: _____

Address: _____

Phone number: _____

I hereby authorize _____ ("Releasor") to
use or disclose the following: (check one)

☐ - **ALL Medical Records.** I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA. Including information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS.

☐ - **Specific Medical Records:**

My medical records shall be disclosed to the following individual or entity:

Nulife Health and Wellness
302 N 168th St # 302 Omaha, NE 681198
Phone: 402-916-1897
Fax: 402-702-0591
E-Mail: Nurse@nulife-health.com

Purpose of Release: _____

This authorization expires one year from this date or on: _____

I understand that signing this authorization is voluntary, and that my treatment, payment, enrollment in a health plan, or eligibility benefits will not be conditioned upon whether I sign this authorization. I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Signature _____

Date: _____