Edenic-Light Humanitarian Institute for Integrative Pastoral & Natural Medicine
Edenic Light Integrative Family Life Care
3695F Cascade Rd #117, Atlanta Georgia, 30331, Tele# 678-592-7289 Fax 1-866-357-6267

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health and or Psychiatric information,

Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health and/ or Psychiatric information as follows:

Patient Name:_____ MRN:_____

Date of Birth_____

Persons/Organizations authorized to use or disclose the information: [1] _____

Persons/Organizations authorized to receive the information (must include name, address, phone number, fax number):_____

This Authorization applies to the following information (select only one of the following): [2]

A. ☼ All health information pertaining to any medical history, mental or physical condition and treatment received.
[Optional] Except:_____

☼ Only the following records or types of health information (including any dates):_____

B. I specifically authorize release of the following information (check as appropriate): [2,3]

- ☼ Mental Health and/or Psycho-therapy treatment information
- ☼ HIV test results
- ☼ Alcohol / Drug treatment information

.

PURPOSE

Purpose of requested use or disclosure: [4] ☼ Patient request; *OR* ☼ Other:_____

EXPIRATION

This Authorization expires (not to exceed 24 months): [5] _____

(Insert Date or Event)

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:_____
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this authorization. [6]
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

(Continued on back)

- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.\

SIGNATURE

Date:_____ Time:_____ a.m./p.m.

Signature:_____

(Patient / Representative / Spouse / Financially Responsible Party)

If signed by someone other than the patient, state your legal relationship to the patient: [8] _____

_____

Witness:_____

Medicall Representative Processing Request:_____ Date:_____

(Signature)

[1] If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

[2] The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

[3] If authorization is for the use or disclosure of protected health information for research, including the creation and maintenance of a research database or repository, the statement "end of research study", "None", or similar language is sufficient.

[4]The requestor is to complete this section of the form.