Love to Live Well.com
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Authorization for Use/Disclosure of Personal Health Information (PHI)

Please complete & sign this form, then **fax to: 940-312-7283 or email a scanned copy to the email address above.**
Failure to provide all information may invalidate this authorization

Patient Information	Patient Name: _____ (Last Name) (First Name) Date of Birth: _____ Home Phone: _____ Cell Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
Release From	I authorize the following **doctors, health professionals, or organizations** to disclose **personal health information from my records** for the purpose of continuing care: 1. Doctor Name: _____ Office Fax: _____ Address _____ Office Phone: _____ City: _____ State: ____ 2. Doctor Name: _____ Office Fax: _____ Address _____ Office Phone: _____ City: _____ State: ____ 3. Doctor Name: _____ Office Fax: _____ Address _____ Office Phone: _____ City: _____ State: ____ **Check all types of information you wish to be shared among practitioners:** _____ Physical Exam ____ Consultation Reports/ Discharge Summaries _____ Lab Results/Reports (past 6 months and any reports with abnormal results) _____ Diagnostic/Pathology Reports (past 6 months and any reports with abnormal results)
Notice of Rights	I understand that: 1. Signing this authorization is voluntary and I can refuse to sign for disclosure of health information. 2. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to: Love to Live Well, 1011 Surrey Lane Bldg 200, Flower Mound, TX 75022. 3. Unless otherwise revoked, this authorization will expire in 24 months. 4. My health record may include information relating to sexually transmitted infections, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services and treatment for alcohol for drug abuse. 5. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of 6. If I refuse to sign this authorization, my refusal will not affect my ability to obtain treatment, but rather may limit the comprehensiveness of care provided by Love to Live Well. 7. I have a right to receive a copy of this authorization.
Signature	Signature: _____ (Patient or Legal Representative) Date: _____ Legal Representative Relationship: _____