Whole Self Wellness, LLC
860-222-0949 *phone*
888-326-5828 *fax*
wholeselfwellnessct@gmail.com
www.wholeselfwellnessct.com

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Authorization for Release of Health Information

Patient Name _____ Date of Birth _____

I, the undersigned patient or legal representative, authorize:

Whole Self Wellness
627 Norwich Salem Turnpike, Unit 2
Oakdale, CT 06370
T-860-222-0949
F-888-326-5828

Andrea Dameron, DNP, APRN, FNP
WSW Physical Therapy

To obtain __ To release ___ the following protected health information to/from:

_____ (Agency)

Address: _____

Phone: _____

Fax: _____

Purpose for Disclosure/Use:

☐ Medical ☐ Legal ☐ Disability ☐ Insurance

☐ At the request of the patient or legal representative

☐ Other (please specify) _____

Requested Information:

☐ **Complete Record** ☐ Abstract Only

Please specify if you need specific reports only:

☐ History & Physical ☐ Laboratory Report
☐ Discharge Summary ☐ X-Ray Report
☐ Operative Reports ☐ EKG Report
☐ Consultations ☐ X-Ray Films (Radiology Dept)
☐ Billing Statement (Patient Accounts Dept)
☐ Other (please specify) _____

Authorization:

Printed name of patient or representative: _____

Signature: _____ Date: _____

Signature of Witness: _____ Date: _____

Expiration: This release expires one year from request or _____