Be the Change Health and Wellness

AUTHORIZATION FOR USE AND RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Individual/Patient/client Insured:

_____________________________ _____________________________ ______________________
Name of Individual Previous Name (s) Birth Date

_____________________________ _____________________________(_____)________________
Street Address city, State, Zip Phone

AUTHORIZES DISCLOSURE OF PROTECTED HEALTH INFORMATION BY AND BETWEEN:

Be the Change Health and Wellness, LLC	____
Individual(s)/agency/organization making disclosure And/or receiving information	Individual/agency/organization making disclosure and/or receiving information
240 N Milwaukee St	_#202________________________________
Street Address	Street Address
Milwaukee, WI 53202	____
City, State, Zip Code	City, State, Zip Code
*(262) 646 – 8288*_______________	____
Phone/Fax	Phone/Fax

INFORMATION TO BE USED AND/OR DISCLOSED:

The following is a specific description of the health information I authorize to be used and/or disclosed: In compliance with applicable law, which require permission to release otherwise privileged information, please release records pertaining to: (Check all that apply)

( ) Mental Health ( ) Developmental Disabilities ( ) Alcohol and/or Drug Abuse
( ) HIV test results ( ) Other (Specify) ______________________________________

For the Following Date(s): From_____________________To________________________

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

( ) Further Medical Care ( ) Coordinating Care for Dependent/Spouse
( ) Insurance Eligibility/Benefits ( ) Claims Resolution ( ) At the request of the individual
( ) Other: (specify)____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: **Right to Receive Copy of this Authorization-** I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization-I understand that I am under no obligation to sign this form and that Be the Change Health and Wellness, LLC may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke This Authorization-I understand that I have the right to revoke this authorization at any time by providing a written statement of revocation to Be the Change Health and Wellness, LLC. I am aware that any revocation will not be effective until received by Be the Change Health and Wellness, LLC and will not be effective regarding the use and/or disclosures of my health information that Be the Change Health and Wellness, LLC, has made prior to receipt of my revocation statement. I understand that the revocation will not apply to my insurance company (if applicable) when the law provides my insurer with the right to contest a claim under my policy. **Marketing-**I understand if Be the Change Health and Wellness, LLC uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information.

Right to Inspect or Copy Health Information to BE used or Disclosed-I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form, to the extent allowed by law and Be the Change Health and Wellness, LLC. I may arrange to inspect such health information or obtain copies thereof by contacting Be the Change Health and Wellness, LLC.

RE-DISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event)__________________________________
If no date, event or condition is indicated, this authorization will expire one (1) year following the date of signature. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:_______________________________________DATE:___________________

*If signed by other than individual, state relationship or legal authority:*____