Clinic Release of Information Form

Client Information

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Email Address: _____

Authorization to Release Information

I, the undersigned, authorize **HyperCharge Wellness Clinic** to:

☐ Release my wellness/health information records to the party listed below.
☐ Obtain my health information from the party listed below.

This authorization applies to the disclosure and/or collection of my personal health information as outlined below. I understand that this may include information about my medical history, diagnosis, treatments, lab results, imaging reports, and any other relevant health information as specified.

Restrictions or Special Instructions (if any): _____

Recipient Information

Name/Organization: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____Fax Number (if applicable): _____

Purpose of Disclosure:

☐ Continuity of Care ☐ Legal Purposes ☐ Personal Use ☐ Insurance ☐ Other (specify): _____

Description of Information to Be Release/Obtained:

☐ Entire Medical Record ☐ Treatment Plans ☐ Imaging Reports ☐ Billing Information ☐ Lab Records
☐ Other _____

Method of Disclosure: ☐ Secure Email ☐Mail ☐ Fax ☐ Pick-up in Person

Acknowledgment and Understanding: I understand that:

- This authorization is voluntary, and I may revoke it in writing at any time, except to the extent that action has been taken based on this authorization.
- Information disclosed pursuant to this authorization may no longer be protected by HIPPA or other privacy laws once released to the recipient.
- This authorization will expire one year from the date of my signature unless otherwise specified _____ (Date).

Signature:

Client/Authorized Representative Signature: _____
Printed Name: _____
Date: _____