Revive
CLINIC AND SPA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____Date: _____

I authorize Revive Clinic and Spa to use or disclose my health information as described below:

1. Type of information: The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated.)

☐ The entire health record	☐ Minimum Data Sheet
☐ Activity documentation	☐ Medication and treatment records
☐ Admission/readmission documentation	☐ Nursing documentation/progress notes
☐ Assessments, flow sheets	☐ Labs, xrays, other diagnostic reports
☐ Care plans	☐ Face sheet
☐ Informed consents	☐ History, exams and other records
☐ Other: Describe specifically	

2. Recipient of Information: The information identified above may be used by, or disclosed to, the following individual(s) or organization(s).

Name		Name	
Address		Address	
Phone Number		Phone Number	
Email		Email	

3. Purpose of use/disclosure. This information described on the previous page will be used for the following purposes:
   a. ☐ Initiated at the request of the patient
   b. ☐ My personal records
   c. ☐ Sharing with other healthcare providers as needed
   d. ☐ Other: _____

Authorization Statements/Signatures

1. I understand that once the above information is disclosed, it may be re-directed by the recipient and HIPAA may no longer protect the information.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a Revive Clinic and Spa staff member. I understand that the revocation

will not apply to information that has already been released in response to this authorization.

3. Unless I specify differently, this authorization will expire _____.
4. I understand that Revive Clinic and Spa will not condition the provision of treatment or payment on the provision of this authorization.

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	