AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:

Patient's Date of Birth: Patient's SSN:

A. Person(s) or Organization(s) authorized to provide the information:

Mary Howley Ryan MS, RD, CEDRD, LD of Beyond Broccoli Nutrition Counseling, 535 Cache Creek Drive, PO Box 1076, Jackson, WY 83001.

B. Person(s) or organization(s) authorized to receive the information:

C. Specific description of the information that may be used or disclosed (including date(s)):

Nutrition, medical and health information discussed in consult(s) during this time period: 1 year from initial evaluation.

D. Specific description of how the information will be used:

To coordinate patient care and provide appropriate treatment.

1) I understand that this authorization will **expire** on _____.

2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the Beyond Broccoli office in writing.

3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).

4) I may **inspect or copy** any information used or disclosed under this agreement.

5) I understand that if the person or organization that receives this information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____
Patient Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to patient

Note:
You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information **(**e.g., the names of your health care provider(s)**)**.

You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD/ research).

YOU HAVE A RIGHT TO A COPY OF THIS FORM
HIPAA Authorization for Release of Information
This form does not constitute legal advice and covers only federal, not state, laws