HIPAA Release of information AUTHORIZATION FORM

I, _____hereby authorize Evolving Wellness and its affiliates, its employees and agents, to release to Evolving Wellness Practitioners/Wellness Advocates working on my case, my personal health information maintained by Evolving Wellness (e.g., information relating to the diagnosis, treatment and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number).

This authorization for release of information covers the period of healthcare from:
a. □ _____ to _____.
OR
b. □ all past, present, and future periods.

I understand that I have the right to revoke this authorization by providing written notice to Evolving Wellness. However, this authorization may not be revoked if Evolving Wellness, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

Name of Evolving Wellness Participant: _____

Signature of Participant: _____

Date:_____

If applicable, Legal Representatives sign below: By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.
Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Evolving Wellness
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