Bella
natural women's care & family wellness

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

****PLEASE FILL OUT ALL FIELDS.****
Allow 7-10 days to transmit your records from BellaNWC to another provider.

I HEREBY AUTHORIZE:	TO SEND MY RECORDS TO:
_____	_____
Address:	**Address:**
_____	_____
_____	_____
Phone: (____) _____-_____	**Phone: (____) _____-_____**
Fax: (____) _____-_____	**Fax: (____) _____-_____**
Is this a transfer of care? (Y/N)	

I. MY AUTHORIZATION

With my consent**, Bella Natural Women's Care & Family Wellness** may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Bella Natural Women's Care and Family Wellness will be my primary care office.

PLEASE SEND A COPY OF THE FOLLOWING RECORDS (ANY OF WHICH APPLY):

All my health information pertaining to these bellow things will be disclosed EXCLUDING (CHECK BOXES TO EXCLUDE) :

- ☐ My health information related to drug abuse
- ☐ My health information related to alcohol abuse
- ☐ My health information related to HIV/AIDS
- ☐ My health information related to psychological or psychiatric conditions

You may use or disclose the following health care information maintained by previous health care providers (CHECK ALL THAT APPLY):

- ☐ My Complete Records
- ☐ My Care Plan
- ☐ My Treatment Record
- ☐ My Lab Reports
- ☐ My Imaging Reports
- ☐ My Pathology Reports
- ☐ My Medication Record
- ☐ My Progress Notes
- ☐ Other (please specify) _____ _____ _____ _____

You may disclose my health information relating to the following treatments or conditions:

_____

Disclose my health information from the dates: _____

Reasons for this authorization (CHECK ALL THAT APPLY):

- ☐ **At my request**
- ☐ **Other(specify):**

_____

II. MY RIGHTS

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- **To receive health care when the purpose is to create health information for third party.**

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above name practice based upon this authorization, I may not be able to revoke this authorization if its purpose was to obtain insurance.

To revoke this authorization, write a letter to the office and it will be put in your chart.
Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ **PATIENT NAME (PLEASE PRINT)**

_____ **FORMER NAME** (IF APPLICABLE)

_____/_____/_____ **DATE OF BIRTH**

_____ **SIGNATURE OF PATIENT** (or legally authorized individual)

_____/_____/_____ **DATE SIGNED**

_____ **RELATIONSHIP TO PATIENT** (if applicable)