HOLISTIC HEALTH
CONCIERGE

Holistic Health Concierge
Authorization for Release and Disclosure of Protected Health Information (PHI)

Patient Information
Patient Name: _____
Date of Birth: _____
Phone Number: _____

Authorization
I authorize Holistic Health Concierge to release, disclose, or discuss my protected health information (PHI) with the individual(s), provider(s), or organization(s) identified below.

Authorized Individual / Organization
Name/Organization: _____
Relationship: _____
Phone / Contact Information: _____

Information Authorized for Release, Disclosure, or Discussion
___ All health information
___ Treatment and healthcare information
___ Appointment information
___ Laboratory/testing information
___ Medication or treatment information
___ Billing/payment information

___ Information limited to the following:
_____

Date Range (if applicable):
From: _____ To: _____

Purpose of Authorization
___ Personal request
___ Family member/caregiver involvement
___ Coordination of care
___ Release to another provider or organization
___ Other: _____

Expiration of Authorization (if preferred)
This authorization will remain valid until:
___ Revoked by me in writing
___ Specific expiration date: _____
___ Completion of this request

Acknowledgment
I understand:
• I may revoke this authorization in writing at any time.
• Revocation does not apply to information already released based on this authorization.
• I may limit what information is shared.
• This authorization is voluntary.

Patient Signature: _____

Date: _____