Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your assessment and treatment information to be shared as requested.

Section 1

I,

Type Full Name *

EX: Jane C. Smith

give my permission for **Diligent Medical Massage, LLC** to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section 4 of this document.

Section 2 - Health Information

I would like to give the above healthcare organization permission to:

Select As Appropriate *

- ( ) Disclose my complete protected health information (PHI) record including, but not limited to, assessments, treatment & treatment plan, and billing records for all conditions.
- ( ) Disclose Everything EXCEPT (Check all that apply)

- [ ] Any PHI disclosed to Diligent Medical Massage, LLC including but not limited to health conditions, diagnoses, treatments, medications, lab and imaging results, etc
- [ ] Assessment information by Diligent Medical Massage, LLC
- [ ] Billing Information
- [ ] Treatment & Treatment plan information.

Form of disclosure *

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'. *

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Individual

Individual's Name

Individual's Phone Number

Individual's Relationship To You

Organization

Organization Name

Organization's Phone Number

Organization's Contact Person

Ex: Dr. Healy

List Additional Individual(s) and Organization(s) Here (Please provide full contact details)

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Select as appropriate:

- [ ] A) Date Range Listed Below:

Indicate Date Range Here:

Ex: From 1/1/2022 to 7/4/2023

- [ ] B) All past, present, and future periods
- [ ] C) The date of the signature in section VI until the following event:

Describe Event Here:

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Elizabeth Dodd, LMBT

Diligent Medical Massage, LLC

105 N. Castle Dr.

New Bern, NC 28562

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Type Name Here *

Signature *

Sign above

Sign above

Date *

MM-DD-YYYY

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name Of Person Completing This Form

Signature Of Person Completing This Form

Sign above

Date

MM-DD-YYYY

Describe below how this person has legal authority to sign this form: