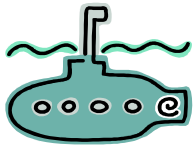
Hyperbaric Wellness Center



2018 Germantown Road South
Germantown, TN. 38138

Please PRINT or TYPE and return to the above address.

Patients Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Social Security Number: _____

I authorize Hyperbaric Wellness Center to obtain and/or disclose a copy of my health information as described below (please check ❑**TO BE OBTAINED FROM** or ❑**TO BE DISCLOSED TO**):

Person or Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Information to be released: ❑Complete Medical Records ❑Laboratory Results ❑Progress Notes ❑Immunization Record ❑Other (Specify): _____

Purpose or need for the information is: _____

I understand that the information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. I understand that the revocation will not apply to information that has already been obtained, used, and/or disclosed under this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. A copy of this authorization may be utilized with the same effectiveness as the original.

If you have questions about the uses and disclosures of your health information at Hyperbaric Wellness Center, please contact us at the address above.

I understand that I can refuse to sign this authorization. I need not sign this authorization in order to obtain treatment, payment, or health plan enrollment or eligibility.

_____ _____
Patient Name (print) Patient or Guardian's Signature

_____ _____
Signature of Patient or Personal Representative* Date

*If Personal Representative, the patient is unable to sign because:
❑Minor ❑Incompetent ❑Other (explain): _____