HIPAA Privacy Authorization Form

1. Authorization

I authorize **Chantelle Lorenz/Roots of Touch Massage Therapy** to use and disclose the protected health information described below to **TriWest Healthcare Alliance and U.S. Department of Veteran's Affairs**.

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. [ ] from _____ to _____ OR
b. [ ] all past, present and future periods

3. Extent of Authorization

I authorize the release of my complete health record relating to massage therapy/healthcare.

4. This information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date/event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and their relationship to patient

_____

Date

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164)