**Authorization for Use or Disclosure**

**Effective:**

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

1- **Authorization**. I authorize (health care provider) to use and disclose the protected health information described below, to a business entity known as *Shel’s My Coach, LLC* (individual or entity seeking information).

2-**Effective Period**. This authorization for release of information covers all past, present and future periods of health care.

3-**Extent of Authorization**. I authorize the release of my complete health records.

4-**Use**. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.

5-**Termination**. This authorization shall be in force for three years or at which time patient chooses to terminate.

6-**Revocation of Rights**. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has 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- **Benefits.** I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sigh this authorization.

8- **Disclosure.** 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.

**Patient Signature:**

**Date:**

**Parent/Guardian Signature:**