HIPAA Release and Authorization Form

This HIPAA Release and Authorization Form allows NuBalance Health to use or disclose your protected health information (PHI) for treatment, payment, and healthcare operations.

Patient Name: _____

Date of Birth: _____

I authorize NuBalance Health to disclose the following PHI:

- Medical records including lab results, prescriptions, and provider notes
- Communication with referring physicians or specialists
- Billing and insurance documentation

Purpose of Disclosure:

[ ] Continued Medical Treatment

[ ] Insurance/Billing

[ ] Personal Use

[ ] Other: _____

I understand:

- I may revoke this authorization at any time in writing
- This authorization will expire one year from the date signed unless otherwise stated
- Information disclosed may be subject to re-disclosure and may no longer be protected

This form complies with federal HIPAA regulations (45 CFR 164.508).

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Contact Phone Number: _____