Our Healing Roots
Complementing Healthcare Naturally

Phone: 417.319.3081
Fax: 1-844-685-0298
760 Short State Hwy P
Seymour, MO 65746

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Full Patient Name:_____
Date of Birth: _____ Phone:_____
Address : _____
I hereby authorize Our Healing Roots, LLC; 760 Short State Hwy P; Seymour, MO 65746
Phone: 417-319-3081/Fax: 1-844-685-0298
☐ **to release the following information to… and/or ☐request the following information from…**

_____
(Name and Address or Fax of Person/Organization Receiving PHI).

Information to be shared:
□ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ **Entire Medical Record**
□ Billing Information for_____ □Mental Health Records
□ Substance Abuse Records □ Medical information compiled between_____ and _____
□ Genetic testing □ Other:_____

The information may be disclosed for the following purpose(s) only:
□ Insurance ✓ **Continued Care** □ Legal □ At my or my representative's request
□ Other:_____

I understand that by voluntarily signing this authorization:
• I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
• I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed. Care will not be withheld for authorization or failure to authorize this record release.
• I have the right to receive a copy of this authorization.
• I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
• My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse. You have the right to refuse disclosure of this information.
• I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
• I understand I cannot restrict information that may have already been shared based on this authorization.
• Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.
Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____
_____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)