



## Authorization to Release Protected Health Information

The privacy practice is/was provided so that I can make an informed decision whether to allow release of the information.

I understand that I do not have to sign this authorization in order to receive treatment from Platte County Wellness Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Platte County Wellness Center  
1305 Plaza Ct  
Platte City, MO 63079  
Phone: 816-858-2167  
Fax: 855-618-2465

By signing, I authorize Platte County Wellness Center to use and/or disclose certain protected health information (PHI) about me to the individual(s) listed below.

This authorization permits Platte County Wellness Center to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

Information requested:

\_\_\_\_\_

\_\_\_\_\_

Date(s) of service: \_\_\_\_\_

The information will be used or disclosed for the following purpose (check one):

Continuing care \_\_\_\_\_ Other \_\_\_\_\_

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian Relationship to Patient

\_\_\_\_\_ Date  
Print Patient's Name

\_\_\_\_\_ Print Name of Patient's Legal Guardian (if applicable)

I authorize the staff at Platte County Wellness Center to release health information to the following individual(s) and/or medical providers

\_\_\_\_\_  
Name Phone Number Fax Number

\_\_\_\_\_  
Name Phone Number Fax Number