Plant Wisdom Within, LLC

Herbs, Nutrition, & Wellness

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Records Release & Health Disclosure Authorization

General Health Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Name:	Date of Birth: / /
Home Address:	
City, State, Zip:	
Preferred Phone:	Email:

I authorize Plant Wisdom Within to disclose/release the following information* (check all that apply):

☐ All records ☐ Billing records ☐ New Client Questionnaire ☐ Herbal/Dietary/Lifestyle Recommendations

☐ Other (describe specifically):

These records are for services provided on the following date(s):_____

Please send the records listed above to (use additional sheets if necessary):

Name:	
Address:	
City/State/Zip:	
Phone:	Fax:

This authorization may be used/disclosed for each of the following purposes:

☐ At my request (only the client can check this box) ☐ For payment/insurance ☐ For my health care

☐ Other (explain):

This authorization shall expire no later than ___/___ /___ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature for Delaware health records.

I understand that after the custodian of records (Plant Wisdom Within, LLC) discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain wellness consultation services. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Printed name of client (or client's personal representative):	Signature of client/representative:
Representative's authority to sign for client (i.e., parent, guardian, power of attorney for healthcare, executor, etc.)	Date

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, disease diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

You have the right to revoke this authorization, except to the extent that the custodian of records (Plant Wisdom Within, LLC) has relied on it, by sending your written request to Joan Greeley, Plant Wisdom Within, 18522 Little Goat Lane, Lewes, DE 19958.

A copy of this signed authorization must be given to the individual.