PATIENT INFORMATION AUTHORIZATION

VIVA! WELLNESS

Patient Name: _____

Date of Birth: _____

This authorization permits VIVA! WELLNESS to use or disclose my protected health information to the following third party or parties:

_____Spouse Spouse's Name: _____

_____Parent/Guardian Parent/Guardian Name: _____

_____Other Name of Individual: _____

_____None

The information that may be used or disclosed to the above person(s) is as follows:

____Entire Medical Record/Healthcare Information
____Name
____Address including street address, city, county, precinct, zip code
____Dates, including birth date, admission date, discharge date, date of death
____Telephone numbers
____Fax numbers
____Electronic mail addresses (email)
____Social Security numbers
____Health plan beneficiary numbers
____Account numbers
____Device identifiers and serial numbers
____Full face photographic images and any comparable images.
____Limited Medical/Healthcare Information
Excluding: _____
____Other (Specify): _____

I understand the information disclosed may be further disclosed by the above-named third party or parties and it may no longer be protected by the Final Privacy Rule.

I understand that I may revoke this authorization in writing to VIVA! WELLNESS, Attention Chief Privacy Officer at 2450 NE Mary Rose Place, Suite 200, Bend, OR 97701.

I understand that I have the right to refuse to sign this authorization and that my treatment, payment for my health care, and health care benefits will not be affected if I do no sign this form.

Signed: _____

Date: _____