Westwood IV Therapy, PC
Contact Privacy Officer: (781) 726-0582

Authorization To Use, Disclose, or Obtain
Personal Health Information

Patient Name: _____
DOB: _____

I understand that, by signing this Authorization, I am authorizing Westwood IV Therapy, PC and its staff (collectively, the "Company") to use, disclose, and obtain my Personal Health Information (defined below).

Authorization for the Company to Use, Disclose, or Obtain Personal Health Information
I understand that this authorization relates to the use, disclosure, and obtaining of my Personal Health Information. It is intended to satisfy the legal requirements of the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d) ("HIPAA") and state privacy laws. I hereby authorize the Company to use, disclose, and obtain my Personal Health Information for the purposes described herein.

Authorization for Specific Types of Personal Health Information
I understand that if my record contains the following types of information, I hereby authorize the Company to use or disclose it for the purposes described herein. **PLEASE INITIAL:**

- Alcohol and drug abuse records…….... **Initial:** _____
- Sexually transmitted disease (STD) records……. **Initial:** _____
- Domestic violence/sexual assault counseling..…. **Initial:** _____ _____
- Mental health diagnosis/treatment records……... **Initial:** _____
  If I want to review my mental health records before they are released, I must initial here: _____. I understand that the review will be supervised.

Persons to Whom the Company is Authorized to Disclose My Personal Health Information
I hereby authorize the Company to disclose my Personal Health Information to, and obtain my Personal Health Information from, the following persons/organizations/categories (collectively referred to as the "Medical Records Recipient(s)"):

Person/Organization	Location/Contact
	[Please fill in, if known]
_____	[Please fill in, if known]
	[Please fill in, if known]

I understand that Personal Health Information disclosed to the Medical Record Recipient(s) may be subject to re-disclosure by the Medical Record Recipient(s) and it may not be possible to protect the privacy of this information once the Company discloses it. I release the Company, its employees, and its subcontractors from any liability arising from the disclosure of this information to such persons/agencies, provided that said disclosure of information is done substantially in accordance with applicable law.

Unless I have specifically requested in writing that the disclosure of information be made in a certain format, I understand and agree that the Company reserves the right to disclose information as permitted by this authorization in any manner that it deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Description and Purposes of Using/Disclosing/Obtaining Personal Health Information
The information covered by this authorization (the "Personal Health Information") includes all information that identifies me that relates to my diagnosis, treatment, payment, criminal record information, healthcare services, continuing care plans, demographic information, treatment progress, and assessment. It includes all information that HIPAA defines as Protected Health Information.

I understand that the purpose of using, disclosing, or obtaining this information is to improve assessment and treatment planning, to share information relevant to treatment, to coordinate treatment services, to improve health care operations, and assist in billing for payment of services. I authorize the payment of benefits for services to go directly to the Company.

My Rights
By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of the above healthcare information. My refusal may result in improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance, or other adverse consequences. The Company will not condition my ability to receive healthcare services or treatment on providing or refusing to provide this authorization.
- I may revoke this authorization at any time, either orally or in writing, by notifying the Company's Privacy Officer at (781) 726-0582 or by email at WestwoodIVTherapy@gmail.com. Revoking this authorization will not apply to information that was already used/disclosed/ obtained in reliance on my having signed this form.
- The health information that is disclosed pursuant to this authorization may be subject to re-disclosure by recipient, and it may not be possible to protect the privacy of this information once re-disclosed.
- I have the right to make a written request to review my records before signing. I have the right to receive copies of my records for a reasonable fee.
- I have a right to a copy of this signed authorization.

I understand that this authorization has no expiration date and will remain in effect until I revoke it as described above, until my treatment relationship with the Company ends, or until the following date (if filled in): _____, 20___.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use and disclosure of my Personal Health Information. By my signature below, I hereby knowingly and voluntarily authorize the Company to use, disclose, and/or obtain my Personal Health Information in the manner described above.

_____ _____

Signature of Patient Date

If the Patient is an unemancipated minor or otherwise incapacitated (physically or mentally):

_____ _____

Signature of Guardian/Personal Representative Date

_____

Description of Authority or Relationship

Revised 5/2022