HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This request form may be returned directly back to the sender or emailed to support@wheel.com

Request

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Information

Patient Name: ____

Date of Birth: ____

Street Address: ____

City, State, Zip: ____

Phone Number: ______________________ Email: ______________________

Scope of Disclosure

I authorize Wheel to use or disclose the following health information: (check one)

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition: ______________________

If your request for records is in excess of fifteen (15) months, please indicate the time frame below.

Standard requests for records contain a fifteen (15) month time period. Records are retained in accordance with HIPAA and other relevant laws and vary from state to state.

From: ______________________ To: ______________________

The purpose of this authorization is: (check all that apply)

- ☐ At my request
- ☐ Other: ____

This Authorization remains in effect until a written notice of revocation is provided to Wheel by emailing legal@wheel.com with the subject line "Revocation of HIPAA Authorization."

Third Party Disclosure (Optional)

☐ **By checking this box, I further request that my health information is directed to the third party at the address designated below: (optional)**

Third Party Recipient: ____

Relationship to Patient: ____

Street Address: ____

City, State, Zip: ____

Phone Number: ______________ Fax: ______________ Email: ______________

Method for Receiving Information

☐ **Fax.** Fax Number: ______________________________

☐ **Email (Encrypted).** In an effort to protect your health information, our standard practice is to encrypt our email.

☐ **Email (Unencrypted). Signature required**. By signing you acknowledge that you understand an unencrypted email exposes your personal and health information to additional security risks.
Signature: ____

If you require your health information in a format other than those listed above, please contact us at legal@wheel.com

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing by emailing legal@wheel.com with the subject line "Revocation of HIPAA Authorization."

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature

Signature of Patient: ____ Date: ____________________

If the patient is a minor or unable to sign, please complete the following:

Signature of Authorized Representative: _________________________________ Date: ____________________

Print Name of Authorized Representative: ____

Note: If you are signing this form as the legal representative of the individual listed above, and are other than the parent of the minor child whose information is listed above, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.