EMPLOYEE WELLNESS, P.A.
1050 SE MONTEREY RD. SUITE 101 • Stuart, FL 34996 • **772-872-7304**
www.**employeewell.com** | Secure Fax: **772-872-7305**

HIPAA PRIVACY RELEASE

PERMISSION TO SHARE YOUR PRIVATE HEALTH INFORMATION

I understand my medical records are protected by federal law and that information can only be released as per the Health Information Privacy and Portability Act.

_____

Patient Name

☐ **I DO NOT AUTHORIZE TO SHARE MY PRIVATE HEALTH INFORMATION**
If checked, please sign the form below

☐ **I AUTHORIZE EMPLOYEE WELLNESS TO SHARE MY PRIVATE HEALTH INFORMATION**
If checked, please provide the information below

SHARE MY PRIVATE HEALTH INFORMATION WITH THE FOLLOWING INDIVIDUAL(S):
Please list Name & Phone Numbers

NOTICE OF VOICEMAIL AND MESSAGES

Voice messages may be left on the phone number(s) provided: ☐ YES ☐ NO

* RESTRICTIONS ON INFORMATION TO BE DISCLOSED

I request the following restrictions on the information disclosed:

☐ Mental Health Records
Do not disclose these records

☐ Communicable Diseases, including HIV/AIDS, Alcohol/Drugs, Genetics
Do not disclose these records

☐ Other _____
Do not disclose these specified records

_____ _____

Patient Signature Date

I understand I can revoke this authorization at any time by submitting a request in writing to **Employee Wellness, P.A.**