Elite DNA Therapy Services, LLC
Authorization to Release Protected Health Information (PHI)

Patient Name: _____ Birth Date: _____ Last 4 digits of S.S. # _____

Address: _____ Phone # _____

I request and authorize Elite DNA Therapy Services, LLC:

[ ] To Release my health information to: _____
(Myself or the Name and Address of Recipient – Specify: Attorney, Insurance, etc.)

[ ] To Obtain my health information from: _____
(Name and Address – Specify: Hospital, Physician, etc.)

Purpose: [ ] Continued Care [ ] Legal [ ] Insurance [ ] Payment or Billing [ ] Personal Use

Date(s) of treatment to be released: _____ to: _____ (enter specific date or dates)

Information to be released: [ ] Medical Record [ ] Test Results [ ] Billing [ ] Other: _____

I would like: [ ] Paper Copies [ ] Fax (number listed below) [ ] An Electronic File Emailed (email listed below)

Fax or Email Address: _____

I understand that:

- I do not have to sign this authorization in order to receive treatment, payment or to be eligible for benefits.
- Release of my information may include information regarding diagnosis and/or treatment from other facilities.
- This authorization will remain in effect for **one year** after the date recorded below.
- This authorization can be taken back (revoked) at any time with a written request to the Privacy Officer.
- Revoking this authorization stops further release but cannot undo any release of information that may have already occurred.
- Once the information is released because of this request, it could be redisclosed by the recipient and the information may no longer be protected by federal privacy regulations.
- Sending an unencrypted/unsecured email or fax poses the risk of the record being viewed by unknown persons.
- You accept the risk of inappropriate disclosure if you request your records to be emailed or faxed.
- **I also understand that my records may include information regarding the diagnosis or treatment for alcohol and/or drug abuse; psychiatric or mental illness; and/or sexually transmitted diseases (STDs), as well as AIDS or HIV information <u>AND</u> that I can limit the release of this type of information.**

DO NOT RELEASE: _____ TO: _____

My signature below authorizes the facility specified above to furnish or obtain the information specified above even though the confidentiality of the information may be protected by Federal and State law and regulations. The facility is hereby released and discharged of any liability, and I will hold the facility harmless for complying with this authorization.

_____ _____
Printed Name of Patient or Guardian Relationship to Patient

_____ _____
Signature of Patient or Guardian Date

Contact Privacy Office at 239.223.2751 or Privacy@elitednatherapy.com with any questions.

Official Use Only

Photo ID was provided: [ ] Yes [ ] No – If No, specify form of patient identification: _____