HIPAA Authorization Form

Dual Focus Wellness

I, _____, give permission to Dual Focus Wellness (Krista Caffrey, DNP, APRN, FNP-C, Hypothetically Yes, LLC d/b/a Dual Focus Wellness and its associated providers) to:

- use the following protected health information, and/or
- disclose the following protected health information that is medically necessary to:

Information to be disclosed includes (check all that apply)

- Medical records
- Treatment records
- Diagnostic records
- Other: _____

This protected health information is being used or disclosed for the following healthcare purposes:

_____

This authorization expires when this signor deems appropriate in writing OR upon occurrences of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:

_____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to LTSU Healthcare at 2015 St. George Drive, Bradenton, FL 34208. Fax number 574-990-4411. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____
Signature of Patient or Guardian/ Healthcare Surrogate

Date: _____

_____
Printed Name of Patient or Guardian/ Healthcare Surrogate