WHOLISTIC Thermography

Authorization to Use or Disclose Protected Health Information - HIPPA

As required by the Privacy Regulations, neither Wholistic Thermography or Essence of Pure Living, may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

Name: _____ Date: _____

Address: _____ Date of Birth: _____

_____

I hereby authorize Wholistic Thermography and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of: **EMI, Electronic Medical Interpretations.**

Patient Health Information authorized to be disclosed: **Thermal Images and related health history received by this office.**

For the specific purpose of: **Interpretation of said client thermal images.**

Effective dates for this authorization (month, day, year) _____ through _____.

I understand that I have the right to:

- Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
- Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
- Inspect a copy of Patient Health Information being used or disclosed under federal law.
- Refuse to sign this authorization.
- Receive a copy of this authorization.
- Restrict what is disclosed with this authorization.

_____ _____

Signature or Patient or Patient's Authorized Representative Date

_____ _____

Authorized Signature of Facility Date