HIPAA

I authorize my protected health information (PHI) to be shared with those listed below, if necessary. I understand that by granting this authorization, I allow WILDWOOD INTEGRATIVE HEALTHCARE, INC., to disclose to a family member, relative and or other individual listed below, health information relevant to my care, or payment(s) related to my care.

This form complies with the federally mandated Health Insurance Portability and Accountability Act (HIPAA). We are required to have in writing with whom we can share your PHI. If you circle YES, please print the person's name.

☐ I authorize Wildwood Integrative Healthcare, Inc. to release my protected health information to:

YES NO Spouse: _____

YES NO Children: _____

_____

_____

YES NO Parents: _____

YES NO Significant Other: _____

YES NO Other:_____

☐ I do not authorize Wildwood Integrative Healthcare, Inc. to release my protected health information.

Patient Signature Patient Name

Witness Signature Date