HIPAA Authorization Form

Patient/Client Authorization for Use and Disclosure of Protected Health Information (PHI)

Instructions: This form allows for the use and disclosure of your Protected Health Information (PHI) as required under the Health Insurance Portability and Accountability Act (HIPAA). Please complete this form to authorize or limit how your information is shared.

Client Information

Full Name: _____

Date of Birth: _____ / _____ / _____ **Phone Number:** _____

Address: _____

Authorization Details

I, _____ authorize Holosyndesis Clinical Research (formerly known as IMT Wellness Clinic) to:

Use and disclose my Protected Health Information (PHI) for the following purposes:

☐ Medical Treatment
☐ Case Management
☐ Coordination of Care
☐ Billing and Payments
☐ Other: _____

Information to be Disclosed

☐ Entire Medical Record
☐ Medication Records
☐ Treatment and Care Plans
☐ Billing Information
☐ Other: _____

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12 North Main Street, Suite 30, W. Hartford. CT 06107 (860) 561-2286 Info@IMTWellnessCenter.com www.IMTWellness.life

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Authorized Recipients

Name of Individuals or Entities authorized to receive my PHI:

1. Name: _____
   Relationship: _____
   Contact Info: _____
2. Name: _____
   Relationship: _____
   Contact Info: _____
3. Name: _____
   Relationship: _____
   Contact Info: _____
4. Name: _____
   Relationship: _____
   Contact Info: _____

Expiration of Authorization

This authorization will expire on: _____ / _____ / _____
(If no date is provided, this authorization will expire one year from the signature date below.)

Revocation

I understand that I have the right to revoke this authorization at any time by providing written notice to UHSS/Holosyndesis Clinical Research. I acknowledge that my revocation will not affect any actions taken before receipt of the revocation.

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Client Rights

1. **Right to Refuse Authorization:** I understand that I am not required to sign this form and that my refusal to sign will not affect my ability to receive care.
2. **Right to Information:** I understand that I am entitled to a copy of this signed authorization and that I may inspect or obtain a copy of my health information as provided under HIPAA regulations.

Signature and Date

By signing below, I authorize the use and disclosure of my Protected Health Information as described above.

Client/Authorized Representative

Signature: _____

Date: ____ / ____ / _____

If signed by an Authorized Representative:

Print Name: _____

Relationship to Client: _____

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