DR. PATTY POWERS MD

WHOLE HEALTH CATALYSTS, P.C.

AUTHORIZATION FOR Dr POWERS TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth_____

I authorize: Whole Health Catalysts, P.C 20304 Timberlake Rd, Lynchburg, VA 24502 Phone 434-382-1825 Fax 434-208-2682
To disclose (Select from options below)

□ Last 5 years (includes office visit notes, labs, X-rays)
□ Other (please specify):_____

Fax To: Person/Facility to Receive Information: _____

Street_____City_____State_____Zip_____

Phone:_____ Fax:_____

Purpose of Disclosure:
□Transfer □Personal □Insurance □Other (Please specify):_____

Authorization to Release Information:

1. I understand that I am giving my permission to disclose confidential heath care records, unless indicated below, relating to, if applicable, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. Special instructions, if any:_____
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in DFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the facility / provider listed above.
3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility/provider listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year from the date of signature. If applicable, insert another date or event of expiration:_____
4. I understand that I will be given a copy of this authorization form upon request. Furthermore, I understand that copying charges will be applied according to State/Federal Law.
5. NOTE: Virginia Law permits a charge for personal copy/transfer of your records. Virginia Rates are pages 1-50 at $0.50 per page, pages 51+ at $0.25 per page, plus postage & handling. Prepayment is required prior to release of records.

Signature of patient or Legal Representative_____Date_____

If signed by legal representative, relationship to patient: _____

Office Use Only

Processed by: _____ Date Processed: _____

Revised Feb 13, 2023