WHITAKER WELLNESS INSTITUTE
MEDICAL CLINIC

P.O. Box 8539, Newport Beach, CA 92658

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Patient Name: ______________________
DOB: ______________________
Phone #: ______________________
Email: ______________________

Address: ______________________
City: ______________________
State: ______________________
Zip: ______________________

As a patient of the Whitaker Wellness Institute (WWI), you are entitled, under federal law, to access your personal protected health information maintained in a "designated record set". In order to process your request for access to this information, please complete this form and mail it to Medical Records at P.O. Box 8539, Newport Beach, CA 92658. When the Medical Records department receives the information, they will verify your identity and process your request. If you have any questions or concerns, please contact the Privacy Officer at Whitaker Wellness Institute (949) 270-0153.

This authorizes Whitaker Wellness Institute Medical Clinic to release information to:

Recipient Name: ______________________
Address: ______________________
City: ______________________
State: ____________ Zip: ____________
Phone #: ______________________
Fax #: ______________________
Email: ______________________
Delivery Method:
☐ Mail ☐ Pickup ☐ Fax ☐ Secured Email ☐ Verbal

This authorizes my medical records to be released from:

Recipient Name: ______________________
Address: ______________________
City: ______________________
State: ____________ Zip: ____________
Phone #: ______________________
Fax #: ______________________
Email: ______________________
Delivery Method:
☐ Mail ☐ Pickup ☐ Fax ☐ Secured Email ☐ Verbal

I understand that WWI may charge me a fee for the copies as follows : $0.25 per page plus any necessary postage and $15 for clerical expenses.

Please specify the health information needed for use or disclosure by checking the boxes below:

❑ Physician Notes
❑ X-Rays
❑ Laboratory Results
❑ Medical Records
❑ Treatment(s) (specify): ______________________
❑ Entire Medical Record
❑ Other (specify):

PURPOSE: The health information disclosed may only be used for the following purposes: ______________________

This authorization is valid for one year from the date signed unless otherwise specified by patient.

Patient Signature ______________________ Date ______________________

If not the patient, print your name and relationship : ______________________

A facsimile or copy of this form is also valid.

OFFICE USE ONLY Verbal Request? ❑ Y ❑ N