



WHITAKER WELLNESS INSTITUTE  
MEDICAL CLINIC

4251 Martingale Way, Suite E, Newport Beach, CA 92660

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Patient Name: _____	Address: _____
DOB: _____	City: _____
Phone #: _____	State: _____
Email: _____	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 4251 Martingale Way, Suite E, Newport Beach, CA 92660. 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 (800) 810-6655.

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.