LAVALLEE WELLNESS, LLC
HIPAA DISCLOSURE AUTHORIZATION FORM

INSTRUCTIONS

If you wish for Lavallee Wellness, LLC to share information about you with another person or organization, please fill out all of the sections below. This will inform Lavallee Wellness, LLC what information you want shared and with whom Lavallee Wellness, LLC may share that information. If you leave any sections blank, with the exception of Section II(B), your permission will not be valid, and Lavallee Wellness, LLC will not be able to share your information with the person(s) or organization(s) listed on this form.

SECTION I

The Client, _____, gives permission for Lavallee Wellness, LLC to share information about the Client listed in Section II with the person(s) or organization(s) that listed in Section V.

SECTION II

A. Health and Personal Information. Please describe the information you want Lavallee Wellness, LLC to share about you. Please include any dates and details you want to share.

_____
_____
_____
_____

B. Permission about Specific Health Information. Please initial on the line(s) next to the information you choose to share.

_____ The Client specifically gives permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

_____ The Client specifically gives permission, as required by M.G.L. c. 111, §70G, to share information in the Client's record about their genetic information.

_____ The Client specifically gives permission to share information in their record about alcohol or drug treatment. If this information is shared, the Client understands that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information.

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request" if you are initiating the request.

_____
_____
_____

SECTION IV – Who May Share this Information.

The Client gives permission to Lavallee Wellness, LLC, 10 Tower Office Park, Woburn, Massachusetts 01801 to share the information listed in Section II.

SECTION V – Who May Receive my Information.

Lavallee Wellness, LLC may share the information listed in Section II with the following person(s) or organization:

_____

Name

_____

Organization

_____

Address

The Client understands that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long this Permission Lasts.

This permission to share my information is good until: _____.

Indicate date or event

If the Client does not list a date or event, this permission will last for one year from the date it is signed.

- The Client understands that they can change their mind and cancel this permission at any time. To do this, the Client needs to write a letter to Lavallee Wellness, LLC and send or bring it to the Lavallee Wellness, LLC address listed in Section IV hereof. If the information has already been given out by Lavallee Wellness, LLC the Client understands that it is too late for them to change their mind and cancel this permission.
- The Client understands that I do not have to give permission to share my information with the person(s) or organization listed in Section V.
- The Client understands that if they choose not to give this permission, or they cancel this permission, they will still be able to receive any treatment or benefits that they are entitled to, as long as this information is not needed to determine if they are eligible for services or to pay for the services they receive.

SECTION VII – Signature.

By signing below, the Client indicate that they have read, understood, and agree to be bound by the terms of this HIPAA Disclosure Authorization Form.

_____ _____

Client/Authorized Representative Signature Date

_____

Print Client's Name

If this form is being filled out by someone who has the legal authority to act for the Client (such as a court appointed guardian or executor or a health care agent), please complete the following:

Print the name of the person filling out this form: _____

Describe how this person has legal authority for the Client: _____

_____