

WOMEN AND MEN'S NUTRITION AND WEIGHT CONTROL CENTERS INC.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This authorization complies with Section 164.508[c] of the HIPAA Regulations effective on April 14, 2004

To; _____
Patient Name _____
Address _____
Date of Birth _____
Social Security No _____

1. I authorize the use of the above named individual's health information as described below.
2. I authorize all doctors and hospitals who have treated me to release and disclose health information as described below.
3. I authorize release of my entire medical records, including but not limited to, medical reports, records, hospital charts, physicians and nurses reports and notes, and all other documents concerning, or in any way connected with, the treatment which was administered to me.
4. I understand that the information in my health records may include information relating to AIDS or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by Women & Men's Nutrition and Weight Control Centers, Inc. or any of its representatives.
6. Except to the extent that action has already been taken in reliance of this authorization, at any time, I can revoke this authorization by submitting a notice in writing to Women & Men's Nutrition and Weight Control Centers, Inc. 4436 Chastant Street, Metairie, Louisiana 70006. Unless revoked, this authorization will expire at the completion of my program with Women & Men's Nutrition and Weight Control Centers, Inc
7. I understand that information disclosed by this authorization may be subject to disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996.
8. I hereby authorize the release of the health information specified above.

[Patient]

Date

(Witness)

Date