Mapahtia Spa

HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for Mapahtia Spa to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Check as appropriate:

_ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions for insurance billing purposes.

_Other (Specify)
_____
_____
_____
_____

Form of Disclosure:
An electronic copy or access via a web-based portal or HIPAA-compliant fax/email

Section III – Reason for Disclosure

Insurance billing & communication purposes

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: Insurance companies that are being billed on my behalf by the provider or business

listed in this document
I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization
This authorization to share my health information is valid:
Check as appropriate
_ From _____ to _____
Or
_ All past, present, and future periods
Or
_ The date of the signature in section VI until the following event:

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:
Name:Francine Oprescu, Owner, LMT
Organization: Mapahtia Spa
Address: 1314 Kauffman Ave, Suite 320 Vancouver WA 98660

I understand that:
In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health Data. I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV. I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: _____ Date: _____
Print your name:
_____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of the person completing this form: _____

Describe below how this person has the legal authority to sign this form:

_____

_____

_____

_____