

Release of Information:

I understand that my medical records may contain information regarding my diagnoses, medications, treatment plans, dates of service and more. I understand that such information is confidential and protected by federal law. I understand that health care treatment cannot be conditioned upon my agreement to sign this authorization for the disclosure or use of my health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient and to be no longer protected by the federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Convo Wellness, LLC., except to the extent that action has already been taken in reliance on it. If not previously revoked by me in writing, this authorization is effective on this date and will expire one (1) year from the date of the signing of this document (unless otherwise specified). I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

What type of release are you requesting? (Check all that apply)

- verbal correspondence
- written correspondence
- I am authorizing Convo Wellness, LLC. to release information to another individual/entity

Please indicate to whom: _____

Please indicate from whom: _____

- I am authorizing Convo Wellness LLC to obtain information from another individual/entity.

Please indicate to whom: _____

Please indicate from whom: _____

What is the purpose of the request? (check all that apply)

- insurance matters
- academic matters
- patient or guardian request
- referral for services
- other _____
- legal matters
- coordination of care

*By signing this document you represent your understanding of the aforementioned information.

