New Heights
Health & Wellness

Authorization for Release of Information (ROI)

Patient Name: _____ **DOB:** _____

Phone: (_____) _____ -_____

1. Information To Be Released

I authorize **New Heights Health and Wellness** to:
☐ Release my medical information
☐ Obtain my medical information
☐ Both release and obtain information

2. Recipient of Information

Information may be disclosed **to/from**:

Name/Organization: _____

Address: _____

Phone: _____ **Fax:** _____

3. Specific Information To Be Disclosed

☐ Entire Medical Record
☐ Lab Results
☐ Imaging/Diagnostic Reports
☐ Medications/Allergies
☐ Immunization Record
☐ Hospital Discharge Summary
☐ Billing/Insurance Records
☐ Other: _____

4. Purpose of Disclosure

☐ Continuity of Care
☐ Insurance/Payment
☐ Legal Purposes
☐ Personal Use
☐ Other: _____

5. Expiration of Authorization

This authorization will expire on:

☐ (Date) _____

☐ (Event) _____

☐ One year from signature date (default if not specified).

6. Patient Rights & Acknowledgment

- I understand this authorization is **voluntary**.
- I understand that once my information is released, it may no longer be protected under HIPAA.
- I may **revoke this authorization in writing at any time**, except to the extent that action has already been taken.
- Refusing to sign will not affect my treatment, payment, or eligibility for benefits.

7. Signature

Patient/Guardian Name (print): _____

Relationship to Patient (if not self): _____

Signature: _____

Date: _____

Witness/Staff Signature: _____ **Date**: _____