



# HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

DATE OF REQUEST: \_\_\_\_\_

This HIPAA Authorization covers all protected health information (PHI) requested by me and maintained by the provider(s) identified below, including any such information created by such provider(s) during a period of up to 1 year after the Date of Request written above, UNLESS this HIPAA Authorization is revoked by me or the following box is checked and a different date range is provided here:  only PHI created/dated between \_\_\_/\_\_\_/\_\_\_ and \_\_\_/\_\_\_/\_\_\_

## 1. PURPOSE OF REQUEST & RECIPIENT

This request is made at the request of  the Individual  the Individual's Legal Representative  Other: \_\_\_\_\_ for the purpose of disclosing the Information identified below to **ZWEENA LLC**, a PHR vendor with offices located at 71 Tamarack Circle, Skillman, NJ 08558, so that Zweena, LLC can collect and maintain such Information for and on behalf of the Individual.

## 2. INDIVIDUAL'S INFORMATION

Name:	Home Address:	
DOB:	Phone #:	E-mail:

## 3. DISCLOSING PARTIES

I hereby authorize the following parties to disclose the identified below to Zweena LLC (check only one) :

**ANY & ALL** health care providers (the "class") that have created or maintain Information about me

**ONLY** the following provider(s):

Provider's Entity Name	Primary Contact Name:	Phone:
1.		
2.		
3.		

## 4. INFORMATION AUTHORIZED FOR RELEASE

I hereby authorize the following **protected health information ("Information")** to be disclosed to Zweena LLC (check only one) :

**My Entire Medical Record**

**ONLY** the following Information (please describe):

## 5. INFORMATION REQUIRING SPECIFIC CONSENT FOR RELEASE

The following categories of Information **should NOT** be disclosed *unless* my signed initials appear next to the category indicating that I specifically consent to the release of such sensitive information pursuant to this Authorization.

___ 42 CFR Part 2 Records	___ HIV/AIDS-related information	___ Psychotherapy Notes
___ Emancipated Minor's Records	___ Psychiatric admits from ED	___ Venereal Diseases (STDs)
___ Genetic Information		

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, as may be amended from time to time ("HIPAA"). I understand that I have the right to revoke this Authorization, at any time prior to the Disclosing Party taking action in reliance on this Authorization, and provided that the revocation is in writing. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature. I understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in my provider's Notice of Privacy Practices. I understand that in the alternative I may send my revocation to **ZWEENA** online at [support@zweenahealth.com](mailto:support@zweenahealth.com) or by fax to **866.560.8543**, and Zweena will ensure that my provider receives my revocation in a timely manner. I understand that I am not required to sign this Authorization and that my provider cannot condition treatment on my execution of this Authorization. I understand that once my Information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient listed above and, in that case, many no longer be protected by HIPAA. This Authorization EXPIRES automatically 1 year from the Date of Request written above.

**I HEREBY ACKNOWLEDGE THAT A COPY OF THIS AUTHORIZATION HAS BEEN PROVIDED TO ME.**

\_\_\_\_\_  
**Signature of Individual (or Legal Representative)** \_\_\_/\_\_\_/\_\_\_  
Date

Authority of Legal Rep:  Court-Appointed Guardian  Parent of Minor  Power of Attorney  Other (specify): \_\_\_\_\_