Enhanced Wellness of Oak Grove
Betty 'Laurie' Ryba, MSN, FNP-BC
56 98 Place Blvd, Hattiesburg, MS 39402
Telephone: (601) 264-7286 / **Fax: (601) 450-4640**
Send records to HIPAA complaint email: ewoakgrove@protonmail.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

Phone No: _____ Patient/Signer Email : _____

- ○ **EWOG to receive records from another provider:** I request and authorize other provider/facility listed below to RELEASE healthcare information of the patient named above to: **Enhanced Wellness OG**
- ○ **EWOG to send records to another provider:** I request and authorize **Enhanced Wellness OG** to release healthcare information of the patient named above to other provider/facility listed below.

Other Provider Name: _____

Facility/Clinic Name: _____

Address: _____

Phone/Fax: P: _____ F: _____

Email (if available): _____

This request and authorization applies to:

- ○ All Dates
- ○ Specific Dates: _____
  - ○ All Protected Health Information
  - ○ Treatment or Condition or Specific: _____
  - ○ Labs / Imaging Only: _____
  - ○ Other (Please specify): _____

Authorization to Release Highly Sensitive Information:

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., including herpes, herpes simplex, human papilloma virus, wart, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (acquired immunodeficiency syndrome), and gonorrhea.

1. ___ YES ___ NO: I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
2. ___ YES ___ NO: I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

This authorization will expire within 90 days after it is signed by default (unless patient authorizes otherwise below.)

____ This authorization will expire within _____ days after it is signed.

Patient/Representative Signature: _____ Date Signed: _____

If representative, relationship to patient: _____

"eSIGNATURE" *This consent document may be signed electronically. You agree your electronic signature is the legal equivalent of your manual signature. You agree that no third-party verification is necessary to validate your E-Signature and that the lack of such certification or third-party verification will not in any way affect the enforceability of your E-Signature.*