DIVINE INTERACTIONS EQUINE FACILITATED WELLNESS, LLC

Mailing/Billing:
P.O. Box 165
Avonmore, PA 15618

Practice Location:
276 PA-156
Avonmore, PA 15618

Phone: 724.567.8988

Fax: 724.567.8989

Email: info@divineinteractionsefw.com

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION A FRIEND/FAMILY MEMBER

Client Name: _____

Date of Birth: _____

Authorized Individual:

_____	_____	_____	_____
Authorized Individual Name	Date of Birth	Relationship to Patient	Phone Number

Please **INCLUDE** the following in this authorization:

_____Emergency Contact Only (At Provider's Discretion)

_____ Mental Health _____ Drug/Alcohol _____AIDS/HIV Status

_____ Other (please specify): _____

Please **EXCLUDE** the following in this authorization:

_____ Mental Health _____ Drug/Alcohol _____AIDS/HIV Status

_____ Other (please specify): _____

I understand that the person (s) listed above are not health care providers, health plans, or health care clearinghouses who must follow the federal privacy standards, and the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be further disclosed without obtaining my authorization.

I understand that this authorization is effective for a period of one year from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the person I authorized above to release the information. If applicable, specify other expiration date here.

This release will be valid for one year from _____ until _____

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my choices.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____