	HOLISTIC HUB LLC AUTHORIATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION	1425 South Columbia Road, Grand Forks, ND 58201 Office (701) 330-1151

PATIENT NAME: _____ **DOB:**_____ **DATE:**_____

Address: _____

As required by the privacy regulations, Holistic Hub LLC. May not use or disclose your protected health information except as provided in our notice of privacy practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office.

EMI Thermography

Patient Health Information authorized to be disclosed: Thermal images and related health history.

For the specific purpose of: **Interpretation of said images.**

Effective date for the authorization: _____
This authorization will expire upon written request.

I understand that the information disclosed above may be re-disclosed to additional parties an no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed in this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patient's Authorized Representative. Date.

_____ _____
Authorized signature of facility. Date.