Lavender Moon

Massage Therapy

Authorization for Disclosure of Protected Health Information to Lavender Moon, LLC

I, the undersigned, hereby authorize ____
Entity Name City State

to disclose information from my medical record. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

PATIENT INFORMATION (Please Print)

Last Name ___________________ First Name ___________________ Middle Initial ___ Maiden Name ___________________

Gender M F

Address ____
Street City State Zip Code

Phone Number ____ Date of Birth ____

Social Security Number _________________________________ Email Address ____

Please check/specify the following type of information including dates of treatment, which may be disclosed pursuant to this Authorization:

Dates of Treatment/Particular Illness/Admission Requested: _____________________________

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Reports
- ☐ Emergency Dept. Records
- ☐ Consultation Reports
  Specify ___________________
- ☐ Outpatient Clinic Notes
- ☐ Specify ___________________
- ☐ X-Ray Reports/Labs/Other Tests
- ☐ Registration Sheets
- ☐ Immunizations
- ☐ Other ___________________
- ☐ Other ___________________
- ☐ ALL INPATIENT MEDICAL RECORDS
- ☐ ALL OUTPATIENT MEDICAL RECORDS

Purpose For Disclosure: ☐ Medical Care ☐ Other ____

Disclose Records To: Lavender Moon c/o Christina Means, LMT 130 Kings Daughters Drive, Suite. 400 Frankfort KY 40601
KY License Number: BMTMTH00217427

Information may be: ☐ Mailed ☐ Reviewed Only ☐ Picked Up By whom: __________________________ ☐ In-Person Meeting

This Authorization will expire 60 days after the date below, or sooner by my choice, in which case, Authorization will expire on ________________, or when ______________________________ occurs.

This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the authorization the individual/parent/legal guardian must submit a revocation request in writing to the entity disclosing protected health information to Lavender Moon, LLC listed above. Please refer to the above entity's Notice of Privacy Practices.

The entity disclosing protected health information to Lavender Moon, LLC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations.

Signature:____ Date: _______________ ☐Patient ☐Parent ☐Legal Guardian*

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If Lavender Moon, LLC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form

*Documentation regarding guardianship must be provided in order to comply with the above request.