RADIANCE
health & wellness

# HIPPA Release Form

**Section I**

I, _____, give my permission for Radiance Health and Wellness to share/obtain the information listed in Section II of this document with the person(s) I have specified in Section IV of this document.

**Section II- Health Information**

I would like to give permission to

_____ Disclose my complete health record including diagnoses, lab test results, treatment and billing records for all conditions.

_____Disclose only the following: _____

Form of Disclosure:

_____ Hard copy

_____ Electronic copy via fax or email

**Section III- Reason for Disclosure**

Please detail the reason why information is being shared.

_____

_____

**Section IV- Who Can Receive My Health Information**

I give authorization for the health information detailed in section II of this document to be shared with the following individuals:

Name: _____

Organization: _____

Address: _____

**Section V-Duration of Authorization**

This authorization to share my health information is valid from:

_____ Specific dates: _____ to _____

_____ Indefinitely

I understand that I am permitted to revoke this authorization to share my health information at any time. I can do this by submitting a request in writing to:

Amy Black
Radiance Health and Wellness
5206 Markel Rd
Suite 302
Richmond, VA 23230

RADIANCE
health & wellness

I understand that by signing this form I do not need to give any further permission for the information listed above to be shared with the person/ organization I have listed above.

**Section VI- Signature**

Signature: _____

Printed name: _____

If this form is being completed by a parent or legal guardian of a minor, please complete the following:

Name of person completing the form: _____

Relation to patient: _____

Signature: _____