FORM 001: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) FROM LIV BY ADVANTIA HEALTH

Section A: This section must be completed for ALL Authorizations

Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**

Provider's Name and Address: Liv by Advantia Health ATTN: Practice Manager 1443 U Street NW Washington, DC 20009 Phone: (202) 481-2050 Fax: (833) 629-0566 Email: liv@advantiahealth.com	**Practice Representative:** **Address:** **Phone:**

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)

Date: **Event:**

Purpose of Disclosure:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in Medical Record		☐ X-Ray Films		☐ Notes from Other Providers	
☐ Registration Sheet		☐ Lab/Test Results		☐ Disability/FMLA Forms	
☐ Medical History Form		☐ Operative Reports		☐ Work/School Notes	
☐ Medication Sheet		☐ Pathology Reports		☐ Itemized Bill	
☐ Office Visit Notes		☐ Other Hospital Information		☐ Other:	
☐ Nurse Notes		☐ Physical Therapy Notes		☐ Other:	

I understand that:

1. **Liv by Advantia Health** will not condition treatment on my providing this authorization, except in the case of my participation in research related treatment.
2. I may refuse to sign this authorization and that it is strictly voluntary.
3. I may see and obtain a copy of the information described on this form, for a reasonable copy fee, by requesting it in writing. Under **District of Columbia** law this information will be provided to me within 15 days of my request.
4. I may revoke this authorization at any time by notifying **Liv by Advantia Health**'s Practice Manager, in writing, of my intent to do so. This will not affect any actions taken prior to receiving the revocation.
5. If the requester or receiver is not a health plan, health care clearing house, or health care provider, the released information mayno longer be protected by federal privacy regulations and may be redisclosed.
6. I acknowledge that I have the right to a copy of this authorization after I have signed it.

Section B: Is the Request of the PHI for the purpose of marketing? Yes ☐ No ☐

If yes, the health care provider must complete Section B, otherwise skip to Section C.

Liv by Advantia Health will ☐ will not ☐ receive financial or in-kind compensation in exchange for using or disclosing this information.

Section C: Signatures

I have read the above and authorize the disclosure of my Protected Health Information as described on this form.

Signature of Patient or Patient's Representative:	**Date:**

Relationship of Patient's Representative, if applicable:

The authority of the patient's representative (attach evidence of authority to this Authorization):

Revision Date: September 29, 2022