HIPAA RELEASE FORM FOR NON-COMPLIANT COMMUNICATION CHANNELS

Patient Name: _____
Date of Birth: _____
Social Security Number: _____
Patient Address: _____
_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, hereby authorize NW Integrative Medicine, LLC. and its authorized representatives to use and/or disclose my health information, including but not limited to video recordings, medical records, and other personal health information, through non-HIPAA compliant communication channels such as Loom, Gmail, and other email systems for the purposes of treatment, payment, healthcare operations, and other purposes as I may direct.

I understand that the channels through which my health information will be shared may not comply with the standards set forth by the Health Insurance Portability and Accountability Act (HIPAA) and that the security and privacy of my health information may be at risk.

I acknowledge that I have been informed of the risks associated with sharing my health information through non-HIPAA compliant channels, including the potential for unauthorized access to my health information by third parties.

I understand that I have the right to revoke this authorization at any time by providing written notice to [Your Practice Name]. I am aware that revocation will not affect any actions taken before the receipt of such notice.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall remain in effect until [Expiration Date or Event], unless I revoke it sooner.

Patient Signature: _____
Date: _____

Signature of Personal Representative (if applicable): _____
Relationship to Patient: _____
Date: _____

NW Integrative Medicine, LLC.
1029 N. Kellogg
Kennewick, WA 99336
509 516-1208

Please provide a copy of this completed and signed form to the patient or their personal representative.