WILSON WELLNESS. LLC ~ LAURA SIMMONS, PT, LLC
1230 N. FALL CREEK ROAD ~ PO BOX 1482 ~ WILSON, WY 83014
307-690-5558 ~ FAX: 307-210-1815

RELEASE OF MEDICAL INFORMATION

- I understand that the PRIVACY PRACTICES of this clinic are strictly respected and followed according to Federal Law: Health Insurance Portability & Accountability Act of 1996. I will receive a copy of HIPAA and/or this completed and signed authorization form upon my request. I hereby authorize the release of any written medical and/or wellness case information on record in this practice for the express benefit of planning my course of treatment with physicians or other health professionals, or at the direct request of an insurance company for the reimbursement of services rendered from this practice.
- I authorize Laura Simmons to verbally discuss details of my case with physicians or health personnel only in direct relation to and as needed to plan my course of treatment.
- I understand that any information shared with Laura Simmons, PT, in the practice of my care, as protected by HIPAA privacy rules, is absolutely confidential and will not be shared in any form, written or verbal, outside of the guidelines authorized by this consent.
  If I wish for my protected health information to be shared in any other form, I will provide a separate written consent. I understand that there will be a reasonable charge with provision of my protected health information outside of what is authorized on this form.
- I understand that I have the right to access my protected health information to be used or disclosed.
- I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA privacy rules.

NAME_____BIRTHDATE:_____

SIGNATURE: _____ DATE: _____