



Ace Health and Wellness Center
14815 N Del Webb Blvd, Sun City, AZ 85351
Ph.(623) 248-1717 | Fax.(623) 248-1688
www.acehealthclinic.com



HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I, _____, give my permission for
Ace Health and Wellness Center PLLC to share the information listed in Section II of this document
with the person(s) or organization(s) I have specified in Section IV of this document.

Section I- Health Information

I would like to give the above healthcare organization permission to:

Tick as appropriate

☐ Disclose my complete health records including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

OR

☐ Disclose my complete health record except for the following information.

- ☐ Mental Health Records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/Drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify)

Form of disclosure:

- ☐ Electronic copy or access via a web-based portal
- ☐ Hard copy
- ☐ Verbal Disclosure from Ace Health and Wellness Staff

Section III- Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write "*at my request*".



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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 individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V- Duration of Authorization

This authorization to share my health information is valid:

Tick as appropriate

☐ a) From _____ to _____

☐ b) All past, present, and future periods

☐ c) The date of the signature in section VI until the following event:

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

Name: Dr. Isha Gupta, or Dr. Srivinas Reddy
Organization: Ace Health and Wellness Center PLLC
Address: 14815 N Del Webb Blvd, Sun City, AZ 85351

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.



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Section VI- Signature

Signature:_____ Date:____/____/____

Print your name:_____

If this form is being completed by a person with legal authority to act on individual's behalf such as parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:
