HIPAA Authorization to Disclose Health Information

Before use, enter Bodicure's legal name and revocation contact. Use only if you choose to authorize disclosure.

PATIENT / INDIVIDUAL NAME | **DATE OF BIRTH** | **PHONE (OPTIONAL)**

1. I AUTHORIZE THE FOLLOWING SOURCE(S) TO DISCLOSE INFORMATION

PERSON, CLINIC, HOSPITAL, SURGEON, OR OTHER PROVIDER AUTHORIZED TO DISCLOSE

PROVIDER ADDRESS OR ADDITIONAL SOURCES (ATTACH A PAGE IF NEEDED)

2. INFORMATION THAT MAY BE DISCLOSED

I authorize the source(s) named above to disclose the following information to Bodicure, as needed for the purpose below: relevant health information, visit summaries, medication and allergy information, care instructions, orders, and information about my treatment or recovery. Do not include specially protected records unless I separately initial and the disclosure is permitted by law.

LIMIT THE INFORMATION OR DATES, IF DESIRED

OPTIONAL: INCLUDE SPECIALLY PROTECTED INFORMATION ONLY IF YOU INTEND TO AUTHORIZE IT (INITIAL EACH)

[ ] Mental / behavioral health [ ] HIV / STI [ ] Substance use treatment [ ] Other:

3. RECIPIENT AND PURPOSE

RECIPIENT AUTHORIZED TO RECEIVE INFORMATION

Bodicure

PURPOSE OF DISCLOSURE

EXPIRATION DATE OR EVENT (REQUIRED)

INDIVIDUAL / PERSONAL REPRESENTATIVE SIGNATURE | **DATE**

IF REPRESENTATIVE, DESCRIBE AUTHORITY TO ACT

You may revoke in writing at any time, except to the extent action has already been taken. Send written revocation to info@bodicure.life or Bodicure's business address. Information disclosed to Bodicure may be redisclosed and may no longer be protected by HIPAA. Bodicure does not condition services, payment, enrollment, or eligibility for benefits on signing; without this form, Bodicure may be unable to request information. Ask Bodicure for a copy of the signed form.

Provider & After-Hours Contact Worksheet

Use this page to help Bodicure reach the right clinician for order clarification or care coordination.

PATIENT / INDIVIDUAL NAME

DATE OF BIRTH

PRIMARY DOCTOR / ORDERING PROVIDER

PROVIDER NAME AND CREDENTIALS

SPECIALTY

PRACTICE / CLINIC NAME

OFFICE PHONE

FAX (IF APPLICABLE)

SECURE EMAIL / PORTAL

OFFICE ADDRESS

AFTER-HOURS AND URGENT CONTACT PATHWAY

AFTER-HOURS / ON-CALL NUMBER

WHO ANSWERS / WHEN TO CALL

BACKUP PROVIDER OR COVERING CLINICIAN

BACKUP / ANSWERING SERVICE NUMBER

CARE COORDINATION NOTES

BEST WAY AND TIME TO REACH THE CARE TEAM

CLARIFICATION-OF-ORDERS INSTRUCTIONS OR PREFERRED CONTACT

PLEASE NOTE

A provider may require its own release form. This worksheet does not replace the signed authorization on page 1, a provider order, or emergency instructions. Do not use Bodicure for emergencies; call 911 when needed.