



**Authorization to Disclose
Protected Health Information**
From The NUNM SIBO Lab

NUNM SIBO LAB
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Patient Information

Patient Name: _____ **Date of Birth:** ___/___/___ **Phone:** _____

Address: _____
Mailing Address City State Zip

I hereby authorize NUNM to disclose my healthcare information to:

Name: _____ **Phone:** _____

Address: _____
Mailing Address City State Zip

Please send information by (select 1 option): **Postal Service, using address above**

Email: _____ **Fax (number):** _____

About your authorization:

This authorization is only for the NUNM SIBO Lab to release SIBO results.
This authorization will expire 180 days from the date of signing. You do not need to submit multiple forms per result unless this expires.
As required by the Privacy Regulations, NUNM Clinics may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.
Understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.
Results sent by email will be sent via encrypted email. If no option is chosen, results will be sent by postal mail service if we have an address on file for the patient or individual named.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits, whether or not I provide authorization to use or disclose Protected Patient Health Information.

Signature of Patient / Parent / Guardian (relationship)

___/___/___
Date