Functional Wellness LLC
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PO BOX 85, Edwards, CO 81632
Phone: 970-376-7779 ~ Fax: 888-376-6372

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES

PATIENT NAME (LAST, FIRST, MI)	*MEDICAL RECORD NUMBER*
ADDRESS	*DATE OF BIRTH*
	PHONE NUMBER
CITY/STATE	*E-MAIL*

By signing this form, I authorize Functional Wellness, LLC located at address listed above to share my protected health information for the purposes of marketing.

For purposes of this Authorization, the following definitions apply:

> ***Marketing*** means communications about a product or service that encourages recipients of the communication to purchase or use the product or service. Marketing also includes any arrangement between the Practice and another party in which the Practice discloses protected health information for the other party to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.

For purposes of this Authorization, "marketing" does **not** include the following:

> Communications made by the Practice describing health-related products or services provided by the Practice, or included in an individual's plan of benefits; communications made by the Practice as part of treatment of the individual; or communications made by the Practice in the course of managing or coordinating treatment of that individual, or for the purpose of directing or recommending alternative treatments, therapies, health care providers, or settings of care.

I understand that, under federal law and the Health Insurance Portability and Accountability Act, the Practice may not use or disclose my protected health information for marketing purposes without my prior authorization. By signing this Authorization, I am giving permission for the uses and disclosures related to marketing, as defined above. I hereby release the Practice and all its employees from any and all liability that may arise from the release of information I have directed. I understand that the Practice may receive either direct or indirect financial remuneration for sharing my information.

I understand that I may revoke this authorization in writing at any time by contacting the Practice at the address listed above, except to the extent that action has already been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. *(Specify expiration date: _____).*

I understand that my treatment, payment, enrollment, and eligibility for care are not conditioned upon my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT or LEGAL REPRESENTATIVE (state relationship to patient)	*DATE*