Regener8 Health & Wellness

Health Information Authorization (HIPAA)

Practice Address:
Regener8 Wellness & Bio-Hacking
1234 Wellness Way, Suite 100
Miami, FL 33101
Phone: (305) 555-0123
Email: billing@regener8wellness.com

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1. Patient Information

Patient Name: _____

Address: _____

Date of Birth (MM/DD/YYYY): _____

Date of Request (MM/DD/YYYY): _____

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2. Authorization of Use / Disclosure

I hereby authorize Regener8 Health & Wellness and its employees or agents to use and disclose my protected health information (PHI) as described below.

a. PHI Authorized for Disclosure

- Lab work
- Medical history
- Physical examinations
- Diagnoses & therapies
- Telemedicine encounters
- Telehealth encounters

b. Purpose of Disclosure

- Bio-identical hormone therapy
- Andropause treatment
- Menopause treatment
- Adult-onset hormone-deficiency treatment
- Weight-loss management
- Stress management

I understand that PHI disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

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3. Patient Rights

- Right to Revoke – I may revoke this authorization at any time by delivering a written notice to Regener8 Health & Wellness. Revocation will not affect uses or disclosures already made in reliance on this authorization.
- Right to Inspect / Copy – I may inspect or obtain a copy of the PHI described in this authorization as provided by federal law.
- Right to Refuse – I am not required to sign this authorization in order to obtain treatment, payment, enrollment in a health plan, or eligibility for benefits.
- Right to Receive Copy – I am entitled to a copy of this signed authorization.
- Right to Restrict Disclosure – I may request to limit the PHI disclosed under this authorization.

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4. Signature & Acknowledgement

Patient Signature	_____
Printed Name	_____
Date (MM/DD/YYYY)	__ / __ / ____

You may revoke this authorization at any time by submitting a written request to Regener8 Health & Wellness.
