WHOLE FOODS MARKET®
MEDICAL WELLNESS
CENTER

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO WHOLE FOODS MARKET MEDICAL AND WELLNESS CENTER

Patient Name: _____ Birth Date: _____SSN: _____

Whole Foods Market Medical and Wellness Center appointment date _____**(Please have records arrive no less than 3 business days before this date!)**

I hereby authorize _____(Healthcare Provider's Name)

to disclose the following protected health information ("PHI"):

____Annual exam – including doctor's notes

____Copies of all records

____Other (list specific PHI): _____

☐ To: Whole Foods Market Medical and Wellness Center
Address: 800 Central Ave, Suite 203 Glendale, CA 91204
Fax Number: (818) 844-2225 Phone Number: (818) 844-2300

☐ Whole Food Market Medical and Wellness Center
Address: 851 W 6th Street, Austin, TX 78703
Fax Number: (512) 480-0214 Phone Number: (512) 542-0500

To: _____
(If patient or patient's guardian wishes to release PHI to another individual or entity)

This authorization shall expire upon (check one) : ___Fulfillment of this request, OR ___ on the following date:_____

This protected health information is being used or disclosed for the following purposes: To facilitate the provision of healthcare services provided to Whole Foods Market employees and dependents of employees_____

I understand that this authorization (i) is subject to Whole Foods Market Medical and Wellness Center's Notice of Privacy Practice (the "Notice of Privacy Practices") and (ii) may be revoked by me at any time by sending written notification to the WFM Privacy Officer at the address listed in the Notice of Privacy Practices. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

I also understand that, subject to the limitations generally described in the Notice of Privacy Practices, the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain healthcare treatment or services, enrollment or eligibility for any benefits, or payment for such treatment or services.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient or Patient's Representative Description of Patient Representative's Authority