



Authorization to Release Protected Health Information (PHI)

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. By signing this paper, you give us your **OK**. We will only give out the PHI that you say we can share. And we will only give it to the people or agencies that you list.

1. Who is the Medicaid Member?

First Name	Last name	Middle initial
Member ID number	Birth date (MM/DD/YYYY)	Phone number
Street		
City, state, ZIP code		

2. Who can the PHI be given to?

Person or company name LIVING AND BALANCE WELLNESS CENTER	Phone number 602-314-6312
Street 10000 N 31st Avenue Suite C 218	
City, state and ZIP code Phoenix, Arizona 85051	
Person or company name	Phone number
Street	
City, state and ZIP code	

3. What PHI can we share?

We will only share the PHI that you **OK**. Tell us the type of PHI by checking the box.

Any information requested
 Health (medical, dental, pharmacy, vision)
 Long term care
 Patient management records

Sensitive Information: (this information may include diagnosis and/or treatment information)

Substance use disorder (alcohol/drug)
 HIV/AIDS
 Sexually transmitted diseases
 Behavioral Health/Mental health (but NOT psychotherapy notes).
 Other (please explain) _____

4. Why are you giving out this PHI?

Reason/Purpose:

5. This form is good for one year unless you give a shorter time below.

My OK is good from: 11/03/2025 TO 11/03/2026

_____ TO _____

MM/DD/YYYY MM/DD/YYYY

By signing below, I understand and agree:

- I can take back my **OK** by writing to the address on this form.
- If you take back your **OK**, it won't take back the PHI we already shared. But we will not share any more of your PHI.
- My chance to sign up for insurance will not change if I don't sign this form.
- Whoever gets my PHI may share it with others. That means laws may not be able to protect my PHI.
- The PHI I **OK** to share may include:
 - Health condition and treatment information
 - Chronic diseases
 - Behavioral/Mental health conditions
 - Substance use disorder diagnosis or treatment (alcohol/drug)
 - Transmissible diseases, sexually transmitted diseases (HIV/AIDS), and genetic marker information
- I can get a copy of this **OK** by writing to the address on this form.
- I understand and **OK** that Living and Balance Wellness Center may share my PHI with a third party for clinical supervision and documentation purposes as part of our Living and Balance Wellness supervision processes.
- Living and Balance Wellness Center will not share my PHI with whom I named unless I sign this form and not with anyone else.

ATTENTION:

- I must sign this form if any of the options below apply.
- I am 18 years of age or older.
- I am under 18 years of age, and I am married or emancipated.
- My state allows me to be treated even if my parents or legal guardian do not agree.
- My PHI being shared may include one or more of the below conditions:
 - Behavioral/Mental health conditions
 - Substance use disorder diagnosis or treatment (alcohol/drug)
 - Sexually transmitted disease (including HIV/AIDS)
 - Reproductive health (including contraception, prenatal care, and abortion)

6. Signature of Member or Authorized Representative.

Signature	Date
Print name	
If a legal representative signed this form, describe the relationship (parent, legal guardian, Power of Attorney, personal representative)	

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the member is less than 18 years old, a parent or guardian should sign for the minor. If you are a representative signing this form, you must send legal proof you can act for this person.

Do you have questions? We can help. Call Living and Balance Wellness Center at 602-314-6312.

Please sign and return this completed form to:

Email: referrals@livingandbalance.com.

Address:
Living and Balance Wellness Center
Attn: Keith Davis
10000 N 31st Ave Ste C218 Phoenix AZ 85051