HIPAA Release of Information Authorization Form

By selecting “Submit” I hereby authorize TeleHealth Medical Group - Regenerative Medical Group and their affiliates, its employees and agents, to release to my personal healthcare provider as identified by me on this website, Stemcell.life , my personal health information maintained by TeleHealth Medical Group - Regenerative Medical Group and their affiliates, its employees and agents, and identified by my unique identifier as provided by Stemcell.life . I further authorize TeleHealth Medical Group - Regenerative Medical Group to release, at my specific instruction, from time-to-time, e-mails containing my personal health information to be sent to certain individuals and/or healthcare providers, whom I will identify at my sole discretion. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is effective from the time of my selection of “Submit” until I revoke this authorization by providing written notice to TeleHealth Medical Group - Regenerative Medical Group at 600 E Chapman Ave, CA 92866. I further understand that this authorization is voluntary and that I may refuse to acknowledge this authorization. Such refusal will preclude from my participation in the stemcell.life Annual Wellness Visit program.