



Integrative Therapies for Prevention, Cancer and Chronic Disease
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's name: _____ Patient's date of birth: _____

To (Primary Practitioner / Physician): _____

I authorize you, your authorized employees and agents to:

- Release medical records to: Discuss with:
 Obtain medical records from: Both release medical records to and discuss with:

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The following information (specify dates): [unless otherwise noted an abstract will be provided] _____

- Discharge summary Operative report Inpatient admission
 History and physical Test results Progress notes
 Consultation reports Emergency Room Clinic _____ (dates)
 Day Surgery Medical records from other facilities
 Other: _____

Information I refuse to disclose: _____

I DO authorize the disclosure of any information relating to the diagnosis or treatment of ALCOHOL or DRUG ABUSE. If I authorize the release of this information, I understand that such information cannot be redisclosed by a recipient without my specific consent.	I DO NOT. _____ (Initial here).
I DO authorize the disclosure of any information relating to the diagnosis or treatment of MENTAL HEALTH.	I DO NOT. _____ (Initial here).
If I authorize the release of Mental Health, I DO NOT want to review the information before it is released.	I DO: _____ (Initial here). I understand that such review must be supervised.
I DO authorize disclosure of information which refers to HIV test results, infection status or treatment information.	I DO NOT. _____ (Initial here).

This disclosure is for the purpose of: _____

I understand that:

- I can refuse to disclose some or all of the health care information in my treatment records, but that refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences. I understand I will not be denied treatment for refusing to disclose information.
- I can revoke all or part of this authorization at any time during this time period by written notice to the Primary Practitioner / Physician except where information has already been acted upon a request for the release of my medical record.

- I can cross out any provision on this form with which I disagree.
- I understand that if information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be redisclosed by the person or entity that receives this information.
- I understand I am entitled to a copy of this authorization, upon request.

**This authorization is effective for one year from the date of signing.
I further authorize future disclosures to the same individual and/or entities during this time period.**

Signature of patient

Date

Signature of Legally Authorized Representative

Relationship and Date

Printed Name of Authorized Representative

Witness