IntegrativeMedical

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Integrative Medical of DFW to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 180 days from the date of signature or at the date or event specified here

I further understand that I may revoke this authorization at any time by notifying, in writing, Integrative Medical of DFW facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there is a charge for photocopies and records provided on electronic media, as permitted by Texas law, unless copies are sent directly to another health care provider.

PATIENT NAME	Last 4 of Social Security Number	Date of Birth
STREET ADDRESS CITY, STATE, ZIP		Telephone Number

Please release the following information for these treatment dates: ____________

The information will be released to: [ ] Patient/Designee [ ] Health Care Entity [ ] Insurance Company [ ] Attorney [ ] Other

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

Purpose of the use and/or disclosure: [ ] Continued Care [ ] Legal [ ] Insurance [ ] Personal Use [ ] Other ____________

Record copy format: [ ] Paper [ ] CD [ ] ____________ **Record copy delivery:** [ ] Pick-up [ ] Mail [ ] Fax to healthcare offi [ ] Email ____________

Information to be released:

Include this information if applicable: ________ Alcohol/Drug ________ Genetics ________ HIV/AIDS ________ Mental Heal
PT INITIALS PT INITIALS PT INITIALS PT INITIALS

[ ] Summary Abstract only (clinic notes, history/physical, procedure reports, pathology, consultations, test results, discharge summai

[ ] Emergency Department
[ ] Discharge Summary
[ ] Medication
[ ] Provider Orders
[ ] Billing Record
[ ] History/Physical
[ ] Nurses' Notes
[ ] Radiology Film
[ ] Complete Chart (Fee)
[ ] Immunization
[ ] Operative Reports
[ ] Radiology Reports
[ ] Consultations
[ ] Laboratory
[ ] Progress Notes
[ ] Other: ____________

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submittii this request.

By typing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release Information request. I consider this as my electronic signature for this request.

____________________ ____________
Signature of Patient or Legal Representative Date

____________________ ____________
Printed Name of Patient or Legal Representative Relationship to Patient

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