

TRINITY *Integrative* MEDICINE, P.A.

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT DATA	Patient Name (Last, First, M.I.)	Date of Birth
	Street Address	Home Phone
	City State ZIP Code	Other Phone (Circle Work or Cell)

Information Released FROM:

Information Released TO:

Name of Clinic	Name (Hospital, Clinic, Attorney, Insurance Company or Individual)
Street Address	Street Address
City State ZIP Code	City State ZIP Code
Phone Number FAX	Phone Number FAX

INFO	INFORMATION to be released: (mark all that apply)		
	<input type="checkbox"/> All Medical Records	<input type="checkbox"/> Medications	<input type="checkbox"/> Laboratory Report(s)
	<input type="checkbox"/> Records about Specific Condition: _____	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Hospital Records
	<input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> History and Physical	

DATES	DATES of information to be released:		
	<input type="checkbox"/> Specific dates of service: _____	<input type="checkbox"/> All Clinic Records	<input type="checkbox"/> Last 1 year
	<input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> Last 2 years	<input type="checkbox"/> Last 6 months

REASON	REASON for release of information:		
	<input type="checkbox"/> Consult with Family Member (named above)	<input type="checkbox"/> Transfer of Medical Care	<input type="checkbox"/> Referral for Medical Care
	<input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> Legal/Litigation	<input type="checkbox"/> Facilitate Treatment
		<input type="checkbox"/> Personal Use	<input type="checkbox"/> Insurance Claim

Authorization Expiration Date or Event: _____ (If left blank, authorization will expire one year from date of signature.)

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. **Trinity Integrative Medicine** will not refuse or restrict my treatment if I choose not to sign the Authorization. A photocopy/fax/scanned image of this authorization will be treated in the same manner as an original. Further, I realize that **Trinity Integrative Medicine** cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections: therefore, **Trinity Integrative Medicine** is released from any and all liability resulting from redisclosure.

Signature of Patient

Date

Signature of Parent/Legal Representative

(Relationship)

Date