The Center for Internal & Integrative Medicine
A Healthy Today Brings A Healthier Tomorrow™

Patient Registration Form

Patient Name:_____ DOB: _____ Gender: ☐ M ☐ F

Preferred Name:_____ Email:_____

Home Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: (___)_____ Cell Phone: (____)_____

Occupation: _____ Work Phone: (____)_____

Employer: _____ SSN: _____

How did you hear about our office?

_____

If you are age 50 or over:

Have you had a Colonoscopy? (Circle Yes or No)	Yes	No
If Yes:	When:	
	Where/Doctor:	
Have you had a Mammogram? (Circle Yes or No)	Yes	No
If Yes:	When:	
	Where/Doctor:	

Emergency Contact Information

Full Name: _____

Phone: (___)_____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

I acknowledge that my signature indicates consent for treatment. I understand that I am financially responsible for payment, whether or not services are covered by insurance.

Signature: _____ **Date:** _____

401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906

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POLICY FOR CANCELED/RESCHEDULED AND NO-SHOW APPOINTMENTS

We strive to schedule appointments in a way that is most convenient for all of our patients. For that reason, it is very important for a patient to notify us at least 24 hours in advance, if you are unable to make your appointment. That allows us to schedule appointments for other sick patients and keeps our office running smoothly.

Breaking an appointment hinders our ability to care for you, as well as others, because we lose a time slot that could have been used to help another patient. Our employees also waste valuable time getting ready for your visit.

Patients who do not show up for their scheduled appointment or cancel/reschedule an appointment with less than 24 hours in advance will be charged a fee of $75.00.

Barring any unusual circumstances, patients that chronically do not show up for their appointments or do not cancel ahead of time, may be dismissed from the practice.

I have carefully reviewed and understand this Policy for Canceled/Rescheduled and No-Show Appointments.

Signature of Patient/Guardian: _____ Date: _____

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PATIENT RESPONSIBILITY AND FINANCIAL POLICY

Thank you for choosing The Center for Internal & Integrative Medicine as your healthcare provider. The following is a statement of our Financial Policy and patient responsibility relating to payment for services, which you are required to read and sign, prior to treatment. Please understand that timely payment of your bill is considered part of your care.

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at every visit. If you are unable to provide proof of insurance, have a plan that we do not accept, or do not have insurance coverage, full payment is required at the time of your visit. If we are a participating provider, we will routinely file a claim for services rendered, although **all co-pays, co-insurance, and deductible amounts are due at the time of service.** If a patient has a plan we do not accept, **full payment is due at the time of the service**; however, we will provide you with a copy of your invoice at each visit, so you can file your claim with your insurance company.

Various Health Insurance Coverage and Reimbursement Plans

The patient understands that insurance companies have different requirements for payment and reimbursement, including, but not limited to, pre-certifications, referrals, authorizations, or medical necessity for treatment. It is the patient's obligation to know the Insurance Company's requirements and ensure that those requirements are fulfilled, prior to receiving treatment. It is the patient's responsibility to obtain any referral or prior authorization that the Insurance Company requires.

Should there be a dispute with your insurance company, we will attempt to resolve it for you. During this time, you will receive a monthly statement that your account shows an outstanding balance for all services. If your insurance company has not paid within ninety (90) days of the treatment date, you will be personally responsible for full payment of that balance. **Your insurance policy is a contract between you and your insurance company. Even though you have health insurance, you are responsible for payment of all services provided by The Center for Internal & Integrative Medicine.** It is your responsibility to immediately update The Center for Internal & Integrative Medicine of any insurance changes, so the correct insurance company is billed for services rendered. Please list The Center for Internal & Integrative Medicine as your Primary Care Provider (PCP) with your insurance company.

Insured Individuals Electing Self-Pay

The patient reserves the right not to file a claim with their health insurance company, and, instead, elect to pay out of pocket for services provided. In that event, the patient is financially responsible for all charges incurred, and payment is due at the time of service. **After the services have been rendered, the patient will not be able to file a claim with their health insurance company due to insurance claim submission requirements. The Center for Internal & Integrative Medicine will not submit any claim to a health insurance company for services where the patient elected to self-pay.** The patient's election to self-pay for certain services does not affect or reduce any out of pocket financial responsibility for future services; the out of pocket costs are defined in the health insurance coverage plan.

Interest, Late Fees, and Collection Costs

We reserve the right to charge interest in the amount of 1.5% monthly (18% annually) on all past due account balances, as provided by state law. A late fee of $20.00 is applied to any item unpaid after insurance has adjudicated the claim (or 60 days from the date of service, whichever is first). Any delinquent account referred to collections will have a $30.00 collections charge applied. In addition, you are responsible for all legal fees, attorney's fees, collection costs, and any miscellaneous expenses related to the collection of delinquent accounts.

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Missed Appointments

If a patient is unable to make a scheduled appointment, at least a 24-hour notice is required because missed appointments are very disruptive to the operation of our office. Furthermore, other patients are deprived from potential appointments. **If a patient misses/cancels/reschedules a scheduled appointment without the minimum 24-hour notice, the patient will be charged a $75.00 fee. This fee is solely the patient's responsibility and cannot be billed to the health insurance provider.** If you repeatedly miss scheduled appointments, you may be asked to seek medical care elsewhere. For more information regarding missed appointments, please review our Policy for Rescheduled and No-Show Appointments.

Returned Check Fees

Anytime a check is returned for insufficient funds; there is a stopped payment on an issued check; or the check is drawn on a closed account, the Patient will incur a $30.00 processing fee. That fee is applied to your personal account balance and must be paid within fourteen (14) days of notification. If a patient has more than two (2) checks returned for insufficient funds, we will require payment in cash or approved credit card for all visits thereafter.

Delinquent Accounts

If a large bill is anticipated and financial arrangements need to be made, a payment program may be arranged with our Practice Administrator, prior to your visit. Failure to resolve any past due accounts, including any returned checks, will result in referral to a collection agency. Any patient, whose account is forwarded to a collection agency, will be dismissed from our practice. If you are on a plan that requires you to be assigned to a Primary Care Physician (PCP) then a copy of the dismissal letter will be sent to the insurance company so they can reassign you to another PCP.

Transferring of Medical Records & Signed Forms

Because there are frequent changes in health insurance coverage and participating providers, it is often necessary for patients to ask that their medical records be transferred to another physician's office. An immunization record and problem list can be provided at no charge. Otherwise, there will be a $25.00 administration fee for records that are transferred. **All paperwork requested to be completed by the office and physician (i.e. FMLA, jury excuses, disability forms, etc) will be subject to a $25.00 fee prior to release of completed forms.**

Nurse Fee

Any procedures performed by the lab nurse (strep screens, lab work, hearing and vision, etc.), that do not require a face-to-face visit with the physician, will incur a nurse fee in addition to the fee for the procedure performed. All appropriate co-pays will apply.

All patients are asked to please check out before leaving the office. It is unlawful to intentionally leave without satisfying your financial obligations after treatment has been rendered. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have carefully reviewed and understand this Patient Responsibility and Financial Policy.

Signature of Patient/Guardian: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED PURSUANT TO THE HEALTH INSURANCE PROBABILITY AND ACCOUNTABILITY ACT (HIPAA), AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding your health information, and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR IIHI IN THE FOLLOWING WAYS:

1. **Treatment:** Our practice may use your IIHI to treat you. For example, we may ask you to submit to laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may use your IIHI in order to write a prescription for you, or we may disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including but not limited to, our healthcare provider, may use or disclose your IIHI in order to treat you or to assist others in treating you. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment:** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurance provider to certify that you are eligible for benefits (and the range of eligible benefits), and we may provide your insurer with details regarding your treatment to determine if the treatment is covered by your insurer. We also may use and disclose your IIHI to obtain payment from third parties, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations:** Our practice may use and disclose your IIHI to operate our business. For example, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. **Appointment Reminders:** Our practice may use and disclose your IIHI to contact you and remind you of an upcoming appointment. We may leave a message on your answering machine about your appointment.
5. **Release of Information to Family/Friends:** Our practice may release your IIHI to a family member or friend that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a caregiver take their family member to our office for treatment of a cold. In this example, the caregiver may have access to the patient's medical information with consent.
6. **Disclosure Required by Law:** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

C. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES (The following categories describe unique scenarios in which we may use or disclose your IIHI):

1. **Public Health Risks:** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the following purposes:

- Maintaining vital records, such as births and deaths
- Reporting abuse or neglect
- Preventing or controlling disease, injury, or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contacting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agencies and authorities regarding potential abuse or neglect of an adult/child(ren) patient (including domestic violence); however, we will only disclose this information if the patient agrees, or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances, related primarily to workplace injury or illness, or medical surveillance

2. **Health Oversight Activities:** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities include investigation, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.
3. **Lawsuits and Similar Proceedings:** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement:** We may release IIHI if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death, we believe resulted from criminal conduct
    - Regarding criminal conduct at our office, including returned checks (non- sufficient funds)
    - In response to a warrant, summons, court order, subpoena, or similar legal process
    - To identify/locate a suspect, material witness, fugitive, or missing person
    - In an emergency, to report a crime (including the location or victim(s) of the crime, or description, identity, or location of the perpetrator)
5. **Serious Threats to Health or Safety:** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization capable of preventing the treat.

D. YOUR RIGHTS REGARDING YOUR IIHI

Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request.

1. **Written Requests:** Written requests must be made to **Privacy Officer, 401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906**. The request should specify the method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions:** You have the right to request a restriction in our use or disclosure of your IHII for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must submit your request in writing to Privacy Officer, 401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906. Your request must describe in a clear and concise fashion:
    a. The information you wish restricted;
    b. Whether you are requesting to limit our practice's use, disclosure, or both; and
    c. To whom you want the limits to apply.
3. **Inspection and Copies:** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about your healthcare, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Privacy Officer, 401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with

your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed healthcare professional, chosen by us, will conduct the reviews.

4. **Amendment:** You may ask us to amend your IIHI, if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. You must submit your request in writing to Privacy Officer, 401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906**.** You must provide us with a reason that supports your request for amendment. Your request will be denied if you fail to submit your request (and the reason supporting your request) in writing**.** Also, we may deny your request if you ask us to amend information that is, in our opinion: (a) accurate and complete, (b) not part of the IIHI kept by or for the practice, (c) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures:** All of our patients have the right to request an accounting of disclosures, which is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment, or non-operations purposes. The use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares information with the nurse, or billing department, using your information to file your insurance claim. You must submit your request in writing to Privacy Officer, 401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date of disclosure, and may not include dates prior to April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice:** You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice contact the Privacy Officer, 401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906.
7. **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. You must submit your complaint in writing to the Privacy Officer, 401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404-836-9906. **You will not be penalized for filing a complaint**.
8. **Right to Provide an Authorization for Other Uses and Disclosures:** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time, in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.
9. Under HIPAA, a doctor's office or other health care provider must allow a patient to request restrictions on use or disclosure of their "protected health information" (PHI). However, except for the cash-payment exception discussed below, the provider is not required to agree to the patient's request.
   The cash-payment exception is as follows: If a patient has paid in full, out of pocket, for a service or item, then the patient may require that the health care provider not disclose PHI pertaining to the service or item to a health insurance provider when carrying out payment or other healthcare operations functions. For example, a patient who believes that he may have syphilis or herpes, and does not want this information to be released to his insurance provider, could pay out of pocket for the doctor's visit, and then demand that the doctor not file a claim for payment with the patient's insurance provider, as would ordinarily occur.
   Note that the restriction does not apply to disclosures made for purposes of treatment. The patient may not use this HIPAA provision to restrict a doctor's release of PHI to other health care providers for purposes of treatment.
10. Under HIPAA, a patient has the right to authorize the use of their medical data for research with regards to the practice. You have the right to request that your IIHI/PHI not be used with regards to research, including patient medical records and billing records. You must submit your request in writing to Privacy Officer, 401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906.
11. Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer, 401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906.

PATIENT/LEGAL GUARDIAN SIGNATURE	RELATIONSHIP TO PATIENT	DATE

The Center for Internal & Integrative Medicine
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PRESCRIPTION POLICY

Thank you for choosing The Center for Internal & Integrative Medicine as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality of care. In order to continue providing the highest quality medical care, and to ensure your safety, we have implemented the following prescription policy.

The Center for Internal & Integrative Medicine encourages patients to bring their current medications in to the office, at the time of their visit, so the Physician can review and authorize all medications in person and process medication refills.

The medical staff uses electronic prescription writing for most medications. Those prescriptions that are controlled (narcotics, sedative, etc.) cannot be sent electronically; they are printed and given to the patient. Controlled prescriptions that are lost, stolen, destroyed, or otherwise misplaced **CANNOT BE REISSUED** in most cases. **Prescription refill request will not be called in after office hours.** For the safety of our patients, refill requests from pharmacies are generally not accepted. To minimize errors inherent in automated refill requests, we require patients to request refills directly. Patients can request refills via the secure Patient Portal and by calling The Center for Internal & Integrative Medicine. When leaving a voicemail message for a refill, please provide the following information:

1. First and Last Name;
2. Date of Birth;
3. Phone Number;
4. Name and dosage of the medication being refilled; and
5. Name, address, and phone number of pharmacy to call in medication.

Please allow two (2) business days to process refill requests. To avoid delay, patients are encouraged to keep a close eye on their medications and request refills in a timely manner. There are certain classes of medications, such as pain medicines, which require a visit with the physician. If it has been longer than three (3) months since the patient has seen the physician, the request for a refill of medication will be automatically denied. The patient will need to schedule an appointment with the physician before a request for a refill can be considered.

Occasionally, a patient may be seen by one of the physicians who is not the patient's regular primary care physician. We respectfully decline to refill routine medications during these visits.

We routinely communicate with pharmacists, your other physicians, and your insurance company. If we learn that you are seeing more than one physician and obtaining prescriptions for controlled substances from someone other than The Center for Internal & Integrative Medicine, our office will no longer be able to provide healthcare services for you. Please keep your medications in a safe place, and remove all labels before discarding empty bottles.

If someone is picking up a prescription for a patient, an **Authorization for Release of Prescription** has to be signed by the patient, in order for the prescription to be released. Please note that prescriptions for pain medication will be released solely to the patient.

I have reviewed the terms of this Prescription Policy and I understand them.

Signature of Patient/Guardian: _____ Date: _____

The Center for Internal & Integrative Medicine
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AUTHORIZATION FOR MEDICAL TREATMENT

Thank you for choosing The Center for Internal & Integrative Medicine as your healthcare provider. The following document is used to authorize medical treatment and release of information. Please review this document carefully and sign at the bottom.

Authorization for Medical Treatment

I hereby authorize The Center for Internal & Integrative Medicine to administer healthcare services, as ordered by my healthcare provider. My healthcare provider has instructed me on the prescribed treatment and I understand the reasons why it is considered necessary, the risks and advantages, possible complications, and alternatives. As with any therapy or treatment, I understand there are known risks, as well as unknown risks. I certify that no guarantees or promises, expressed or implied, have been made to me regarding my treatment and services. I have discussed all of these matters with my healthcare provider and I desire to undergo healthcare treatment. Additionally, I hereby give my permission for referrals to the appropriate Physician, Hospital, Lab, Urgent Care, or Medical Facility which can provide the optimal care for my illness or injury. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my care.

Assignment of Benefits

I hereby assign to The Center for Internal & Integrative Medicine all benefits and payments to which I am entitled from whatever source, including Medicare, Medicaid or other federally funded programs (my 'insures"), for any services, equipment, or supplies that The Center for Internal & Integrative Medicine provides to me in conjunction with any of my care. I authorize The Center for Internal & Integrative Medicine to bill my insurers directly and receive payment on my behalf. I understand that my assignment of benefits is ongoing and continuous unless I provide The Center for Internal & Integrative Medicine a written revocation.

Release of Information

I authorize the release of my medical or other information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), required for treatment, payment, or healthcare operations, to The Center for Internal & Integrative Medicine or its agents. I permit a copy of this authorization to be used in place of the original.

I have carefully reviewed and understand this Authorization for Medical Treatment.

Signature of Patient/Guardian: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL COMMUNICATIONS

I hereby authorize The Center for Internal & Integrative Medicine to contact me regarding confidential information, including but not limited to: follow-up calls, lab test results, diagnoses, etc. in the manner described below.

Patient Name: _____

Preferred Mailing Address: _____

Preferred Contact Phone Number: _____

I hereby authorize The Center for Internal & Integrative Medicine to provide me with confidential information via:

( ) The above-listed Preferred Phone Number

( ) The above-listed Preferred Mailing Address

( ) Both

( ) Neither; I prefer to receive my confidential information in person only

_____ _____ _____

PATIENT SIGNATURE **PRINT NAME** **DATE**

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MEDICAL RECORDS RELEASE AUTHORIZATION

Patient's Name		**DOB**	
Patient's Current Address:			
Patient's Previous Address:			
Patient's Current Phone #:		**Email:**	
Previous Provider:			
Address:	**City:**	**State:**	**Zip Code:**
Office Phone:	**Office Fax:**		

Release the Personal Health Information (PHI) to:

The Center for Internal & Integrative Medicine
401 S Main St, Unit B-3
Alpharetta, GA 30009

Phone: 404-836-9906
Fax: 470-545-4768

Description of Information to Be Disclosed

☐ **Physician Notes** ☐ **Complete Chart** ☐ **Lab Results** ☐ _____

Reason for Requested disclosure: To transfer or facilitate the medical care of the individual listed above

Please Read and Sign

I understand the following:

1. I authorize the release of Personal Health Information (PHI) to The Center for Internal & Integrative Medicine.
2. I may revoke the authorization at any time by providing written notice to the practice.
3. I may not be able to revoke this authorization it the practice has already taken action utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
4. The practice will not condition treatment or payment based on my signing this authorization.
5. I am signing this authorization freely; no one has pressured or coerced me to sign this authorization.
6. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal or state law.
7. I knowledge that I had an opportunity to review this authorization and understand its content.
8. I understand that I am entitled to a copy of this authorization, at the time of its execution. If I desire a copy, I will make my request known.
9. I understand that the information in my records may include information relating to sexually transmitted diseases, AIDS, HIV, Behavioral or Mental Health Services, treatment for alcohol and/or drug abuse.
10. I am giving my authorization to email my lab results to the email address provided.

_____ _____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE **RELATIONSHIP TO PATIENT** **DATE**