THE CENTER FOR INTERNAL & INTEGRATIVE MEDICINE
AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name:____ **DOB:**______________________________

Patient's Current Address:____

Patient's Previous Address:____

Patient's Current Phone #:____

INFORMATION TO BE RELEASED

___ ***Immunization Only*** ___***Test Results*** ___***Complete Medical Records***
($25.00 Fee Due Prior To Delivery of Documents)

REASON FOR REQUEST

☐ **Personal Records** ☐ **Specialist/Referral** ☐ **Insurance** ☐ **Legal** ☐ **Transferring Out**

Transferring Reason: ☐ **Relocation** ☐ **Change Insurance** ☐ **Unhappy with Staff/Practice**
☐ **Other:**____

DELIVERY OF RECORDS

☐ **Pick Up In Person** ☐ **Via Regular Mail** ☐ **Fax :** ____________________

RELEASE INFORMATION TO

NAME:____

ADDRESS:____

CITY:___________________________ **STATE:** ___________________________ **ZIP:**_____________________________

*****By signing below, I understand that: (1) I release The Center for Internal & Integrative Medicine and its employees, agents, officers, and affiliates from any and all liability, responsibility, claims and damage, which may result from the release of information authorized by this Authorization to Release Medical Records; (2) This consent is valid from the date signed and continues until I revoke this authorization by giving The Center for Internal & Integrative Medicine written notice; (3) I may revoke this authorization at any time, unless the action has already been taken or 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 and voluntarily; (6) No one has pressured me to sign this authorization; (7) I acknowledge that I've had an opportunity to review this authorization and understand its terms; (8) The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal or state law; (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.**

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

PLEASE FILL OUT BELOW IF PAYING BY MASTERCARD, VISA, DISCOVER, OR AMEX	
☐ MasterCard ☐ Visa	☐ Discover ☐ American Express
CARD NUMBER	**3 OR 4 DIGIT VERIFICATION NUMBER**
SIGNATURE	**EXPIRATION DATE**