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

AUTHORIZATION FOR RELEASE OF PRESCRIPTION MEDICATIONS

I, _____, hereby authorize The Center for Internal & Integrative Medicine to release my prescriptions to _____ _____, in the event that I am unable to pick up my prescriptions.

*****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 for Release of Prescription Medications; (2) This authorization 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; (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.**

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