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

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**

Initial: _____