AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

PATIENT INFORMATION

Patient Name: _____ **Date of Birth**: _____

Street Address: _____

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

Patient's Phone: _____

Doctor's Name/Medical Facility:_____

Phone:_____ Fax:_____

Please ***disclose*** the following protected health information ***to***:

Center for Integrative Health

755 Mt Vernon Hwy NE Suite# 350

Atlanta, GA, 30328

Office: 404-255-5774 Fax: 404-255-5994

Please indicate the information or ***types of information to be disclosed***, including dates if necessary:

_____

Specify Dates (or date ranges) if necessary: _____

This request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in six months or on this date listed _____.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE; ____DO NOT RELEASE (Indicate with a check mark).

_____ _____

Signature of Patient or Authorized Representative **Date**

_____ _____

Representatives Authority to Act on Behalf of Patient Signature of Witness