STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is designed for you, as the patient, to give permission for the following individuals to be able to have full access to all of your information including medical and financial records. Individuals not listed on this form will not have access to your medical and financial records.

I, ____, AUTHORIZE RESTORE Center for Integrative Medicine to disclose all information including medical and financial records to the following:

Name: __________________________________

Phone: __________________________________

Relationship to the Patient: ____

Name: ___________________________________

Phone: ___________________________________

Relationship to the Patient: ____

Name: _____________________________________

Phone: _____________________________________

Relationship to the Patient: ____

____ Please check here if you do not wish to authorize the release of your medical information.

EXPIRATION DATE OF AUTHORIZATION

This authorization is effective unless revoked or terminated by the patient or the patent's personal representative.

RESTORE

Center for Integrative Medicine

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to **RESTORE Center for Integrative Medicine.**

POTENTIAL FOR RE-DISCLOSURE

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

____

Name of Patient (Please print)

____

Signature of Patient/Guardian/Legal Representative

____

Relationship to Patient

_______/_______/__________

Date of Birth

______/_______/___________

Today’s Date