Integrative Healthcare Providers
2800 South State Street, Suite 215, Ann Arbor, MI, 48104
Phone: 734-547-3990 Fax: 734-547-3980

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:
Date of Birth:
Address:
City/State/ZIP:
Phone Number:

I authorize the professional office of my physician named above to release and ask for the release of health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions.

Detailed description of the information to be release:

_____

_____

_____

Name and address of health provider or entity to release information:

_____

_____

Name and address of health provider or entity to whom the information will be sent:

Fax records to Integrative Healthcare Providers Fax #734-547-3980_____
Provider:_____

The purpose of this release:
Continuity of care

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.
If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization send us a written or electronic request.

When your health information is disclosed as provided in the authorization, the recipient often has no legal duty to protect it's confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

Patient Signature:_____ Date:_____

Guarantor Signature:_____
(if patient is a dependent minor)