ARIA INTEGRATIVE MEDICINE
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Authorization to Release Patient Health Information

Patient Name _____ Medical Record # (if known): _____
Date of Birth: _____ /_____ /_____

I authorize the following organization to release information as stated below from the patient health record

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
☐ Aria Integrative Medicine	☐ Aria Integrative Medicine
☐ _____ Organization/Person	☐ _____ Organization/Person
_____ Street Address City, State, Zip	_____ Street Address City, State, Zip
_____ Phone Fax	_____ Phone Fax

INFORMATION TO BE RELEASED

Dates of service for records requested: Beginning: _____ Thru: _____

☐ Radiology Reports (X-ray, US, MR, CT, PET) ☐ Lab/Pathology Reports ☐ Clinic Notes ☐ Radiology CD

☐ Complete Records (Does not include billing information or radiographic images) ☐ Other: _____

PURPOSE OF RELEASE

☐ Adjunctive/Concurrent Care ☐ Copies for Own Use ☐ Transfer of Care ☐ Legal

☐ Other (Specify): _____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- My healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law.
- If I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected
- Any Disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of the signing.
- <u>If I request records for personal use, to hand-carry to another health provider, or for parties not involved in my health care, there may be a charge</u>.

I understand that unless revoked, this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

<u>Unless specifically excluded,</u> this authorization includes release of specially protected information requiring my explicit authorization for release
Check the box(s) below to <u>EXCLUDE</u> the information from authorization

☐ Substance Abuse ☐ Mental Health Conditions/Psychotherapy ☐ Sexually Transmitted Diseases and ☐ HIV/AIDS

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

_____ _____ _____ _____
Signature of Patient Date Signature of Legal Representative Date