AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: ________________________________ **Phone Number:** ____________________________

Other Names Used: ________ **Date of Birth:** ___________ __**Social Security Number:**_____ - ________- _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR: PLEASE SELECT ONE OPTION

Continuing Medical Care   Military   Personal Use   School   Insurance

Legal Purposes   Social Security/Disability   Other: ____

DATE (s) OF TREATMENT: ____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical   Consultation Report   Emergency Room Record

Operative Reports   Discharge Summary   Immunization Records

Lab/Pathology Reports   Radiology Reports   All Health Records

Radiology Images   Other: _______________________

METHOD OF DELIVERY:

Secure Fax (210) 888-1867   Paper/Mail

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:____________________________________ **Facility Phone:**______________________

Facility Address:______________________________**City,State,Zip:**______________________________

This information may be disclosed and used by the following individual or organization:

Integrative Family Medicine, PA - Dr. Simone L. Norris, M.D

(Name)

18720 Stone Oak Parkway, Suite 201 SA, TX 78258   (210) 888-1817 (210)888-1867

Address (Street, State, Zip Code)   Phone Number   Fax Number

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation in person to Integrative Family Medicine, PA. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: __________________ . If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Date: ______________________________   Signature: ____

Patient or Legally Authorized Representative

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Printed Name of Patient or Legally Authorized Representative

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Relationship to Patient