

CENTER FOR INTEGRATIVE MEDICINE
1100 E. Third Street, Suite G 100
Chattanooga TN, 37403
Phone: 423-643-2246 Fax: 423-643-2030

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

**** All sections of this form MUST be completed before signing ****

Re: Name _____

Date of birth _____ SSN _____

Patient address _____

Relation to client _____

I hereby authorize the Center for Integrative Medicine to release copies of my records, as listed below, to:

Name of Physician or institution: _____

Address: _____

City/State/Zip _____ Phone/Fax _____

NOTE: information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by the Center for Integrative Medicine

DATES OF TREATMENT (which **specific** dates of treatment do you need records for?)

Dates: _____

Information to be released:

- History and Physical
- Office Visit Notes
- EKG
- Radiology Reports
- Lab
- Other (be specific) _____

Purpose of Release:

- Attorney
- Social Security
- Continuation of Care
- Disability
- Insurance
- Billing
- Other _____

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation, however, will only be effective from the date it is received in this office and will not apply retroactively.

Patient initials _____

Signature of patient or patient's representative Date: _____

A faxed signature is also valid. Signature is only valid for 90 days from date signed

Witness Date: _____