Institute for Progressive Medicine

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Authorization to Release Confidential Health Information

(This release gives permission to *discuss* your personal health information with a third party, this *is not* a records release form)

This authorization permits the following person(s) or class of person(s)

_____

(Name of your Physician, hospital, insurance)

To discuss and/or disclose my protected health information to the following third party or parties:

_____

(Name of person *receiving* information)

The information that may be used or disclosed is as follows:
_____All patient information
_____ Visit notes
_____ Hospital notes
_____ Prescription information
_____ Supplement recommendations
_____ Laboratory results (including pathology, cytology, blood)
_____ X-ray, EKG, U/S, All imaging results
_____ Other
(Specify)_____

By signing this form, I hereby authorize reciprocal information to be shared between the above named parties or agencies. I hereby authorize the release of *any and all* information.

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, the authorization expires _____.

I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization **BEFORE** any information can be discussed with any third party. I may refuse to sign, but in that event, no medical information can be discussed.

I further release my attending physician, consultants, the facility, and employees from any liability arising from the release of information to the person(s) or agency designated above.

I understand that I have a right to receive a copy of this authorization upon my request.

Patient's Name___ _____Date of Birth_____

Address_____

City_____State_____Zip_____ Phone No._____

Signed_____Date_____
(Signature of patient/Parent/Patient's Legal Representative*)

Relationship to Patient_____

*Authorized representative must submit copies of legal documents supporting assignment of this authority.