Cape Integrative Health

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Name of Patient:_____ Date of Birth:_____

Release of Information From:_____

Release of Information To:_____

Purpose of Release

___Transfer of Care ___Legal Purposes ___Payment of Insurance Claims

___Personal ___Disability Determination ___Workers' Comp Claim

_____Application for Insurance ___Other

Information to be Released

___Last 1 year of records ___Office Visit Notes ___Radiology

___Last 3 year of records ___Consultation Report ___Labs

___Entire Medical Record ___Other

Sensitive Information to be Released

I understand that the information to be released may contain sensitive information. My specific authorization is necessary to release information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse, or HIV?AIDS status. Please check the following authorizations.

Mental Health ___I DO Authorize ___I DO NOT Authorize

HIV/AIDS ___ I DO Authorize ___I DO NOT Authorize

Substance Abuse ___I DO Authorize ___I DO NOT Authorize

Cape Integrative Health will not condition treatment on the signing of this Authorization. I may refuse to sign this authorization. If I refuse to sign this authorization, it may result in an improper diagnosis, treatment, denial of coverage, denial of a claim for benefits, denial of other insurance, or other adverse consequences. Information used or disclosed pursuant to an authorization may be subject to redisclosure by the recipient and no longer protected by the rule.
I understand that I may revoke this authorization by notifying Cape Integrative Health in writing of my desire to revoke it except to the extent that action has been taken in reliance upon the authorization.

This authorization expires 30 months from the date here: _____
I, the undersigned, hereby authorize the release of protected health information described above subject to the restrictions described above:
Signature:_____ Date:_____

Print Name of Person Signing (If not the patient) _____
Relationship to Patient (If not patient) ____Parent ___Legal Guardian ___Power of Attorney