Champlain Center for Natural Medicine

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Authorization to Release Personal Healthcare Information

Patient Name: ______________________________________ **Date of Birth:** _______________

I authorize the disclosure and use of my health information as describe below:

To be Released by:

____

____

____

____

To be Received by:

____

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____

____

For the purpose of: ❍ Adjunctive/Concurrent Care ❍ Transfer of Care ❍ Other: ____________________

I specifically authorize the release of the following information:

❍ Complete Chart Record *(does not include billing information or radiographic images)*

❍ Chart Notes: ❍ All ❍ Specify:____

❍ Labs/Reports: ❍ All ❍ Specify:____

❍ Billing Records: ❍ All ❍ Specify:____

❍ X-rays/Radiographic Images (specify): ____

❍Other: ____

Unless specifically excluded, this authorization includes the release of specially protected information: referral, diagnosis and treatment information related to substance abuse, mental health/psychotherapy, and HIV/AIDS.

Check the accompanying box(s) below to EXCLUDE the information from authorization:

❍ substance abuse ❍ mental health/psychotherapy ❍ HIV/AIDS

I understand the conditions of this authorization:

1. Unless canceled by me, this authorization is valid for 12 months from the date of signing.
2. I may cancel this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
3. If the person/organization receiving the health information is not a health plan or heath care provider, the released information may no longer be protected by state and federal privacy regulations.
4. Not agreeing to or canceling this authorization may result in improper diagnosis or treatment, or denial of health benefits or other insurance coverage, but is not a condition for receiving medical treatment.
5. I am entitled to a copy of this authorization form at the time of signing.

____

Patient's Name (PRINT)

____

Signature of Patient

____

Date

____

Patient's Guardian/Representative (PRINT)

____

Signature of Guardian/Representative

____

Relationship to Patient/Representative

____

Date