**AUTHORIZATION TO ACCESS OR RELEASE MEDICAL INFORMATION**

Patient Name: Date of Birth: .

Address: City, State, Zip: .

Phone: Email: SSN: .

\_\_\_\_I request that Balance Integrative and Infusion/Kelli Dudley, FNP-C release my records to the following person or facility:

\_\_\_\_I request that the facility below release my records to Balance Integrative and Infusion/Kelli Dudley, FNP-C:

Name: . Address: . City, State, Zip: . Phone: Fax: .

*Include this information if applicable: \_\_\_Alcohol/drug \_\_\_HIV/AIDS \_\_\_Genetics \_\_\_Mental Health \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_All Medical Records \_\_\_Immunization Record \_\_\_Lab reports \_\_\_X-Ray/Imaging reports \_\_\_Summary information (clinic notes, history & physical, operative reports, pathology reports, consults)*

*\_\_\_Limit information to records regarding specific illness/injury/mental health (condition and/or approximate dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSE(S): \_\_\_Continued care \_\_\_Insurance \_\_\_Personal Use \_\_\_Attorney/Legal

I have read and understand the following terms and conditions of this request:

* I understand authorizing the use or disclosure of the information listed above is voluntary and I am not required to sign this authorization to obtain treatment at Balance Integrative and Infusion.
* If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to re-disclosure by the recipient.
* I may revoke this authorization in writing at any time except to the extent Balance Integrative and Infusion has already relied on this authorization.
* My record may contain information that only a physician can interpret. I will contact my physician if I have a question about my diagnosis or treatment. I will not hold Balance Integrative and Infusion liable for any misinterpretation of information if I fail to contact my physician for clarification.

This authorization will expire in 180 days or at the date specified here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initial here) \_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative Relationship to Patient Date