CONSENT FOR RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME, AND CHECK ONE OF THE FOLLOWING.

I,_____, the ☐ patient ☐ legal next of kin or, ☐ legal
NAME
guardian (*for the patient*), hereby authorize Creekside Center for Integrative Medicine, (_____) to release the following information from the medical
PROVIDER
records of: _____,and ___/____/___. Medical information release from,
NAME OF PATIENT **BIRTHDATE**
___/____/___ and ending ___/___/____ .
DATE **DATE**

INFORMATION TO BE DISCLOSED

PLEASE CHECK ALL APPROPRIATE BOXES:

- _____ SUMMARY OF MEDICAL HISTORY / TREATMENT
- _____ LABORATORY / DIAGNOSTIC TESTS
- _____ ALL RECORDS, INCLUDING ANY RECORDS IN THESE SUBJECT AREAS.
  - _____ HIV / AIDS
  - _____ SEXUALLY TRANSMITTED DISEASE
  - _____ MENTAL ILLNESS OR MENTAL HEALTH TREATMENT
  - _____ OTHER _____
    _____

PERSON / ORGANIZATIONS TO *SEND* MEDICAL RECORDS TO

NAME OF DOCTOR / PERSON /ORGANIZATIONS **COMPLETE ADDRESS / FAX OR PHONE #**

_____ _____
(NAME) _____
_____ _____
(ORGANIZATION / CLINIC)

Staff from Creekside Center for Integrative Medicine may discuss my medical condition and treatment with those persons or organizations listed above.

REDISCLOSURE PROHIBITED: **This information has been disclosed from records whose confidentiality is protected by state or federal law (42CFR Part 2). These laws prohibit making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law**.

I release Creekside Center for Integrative Medicine staff and counsel from all legal responsibility or liability that may arise from authorized release of information.

I understand I may revoke this consent at any time. This consent expires on _____, or in (90) days unless otherwise specified.
(DATE)

_____ _____
SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE CONSENT) **DATE**