



AUTHORIZATION TO RELEASE PERSONAL HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth _____

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

To be Released by:

To be Received by:
Biologic Integrative Healthcare LLC
205 Main Street, Suite 4
Brattleboro, VT 05301

Phone/FAX _____

Phone 802-275-4732 Fax 802-275-4738

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: _____
- Lab Results: All Specify: _____
- Imaging Reports: All 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 health 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)

Patient's Guardian/Representative (PRINT)

Signature of Patient

Signature of Guardian/Representative

Date:

Relationship to Patient/Representative

Date: