VITAE
INTEGRATIVE MEDICAL CENTER

MEDICAL RELEASE OF INFORMATION

Patient Name (Please Print) _____Phone#_____

Date of Birth _____ **Date** _____

I authorize: _____

To release my health information to: Vitae Integrative Medical Center LLC.

Purpose of disclosure:_____

I specifically authorize the use or disclosure of the following health information:

____ ALL MEDICAL RECORDS
____ Radiology Reports _____ from _____ to _____
____ Chart Notes **ALL** or from _____ to _____
____ Labs **ALL** or from _____ to _____
____ Billing Statements
____ Other (please list)_____

____ Verbal exchange of information between providers

I understand that I may revoke this authorization at any given time by giving written notice. I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

_____

Signature of Patient or Patient's Legal Representative

_____

Print name of legal representative (if applicable) Relationship of Legal Rep. to patient

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