VITAE
INTEGRATIVE MEDICAL CENTER

Medical Record Release: Authorization for Release of Information

Patient Name: _____ DOB: _____
Other Name (*if applicable*):_____

PLEASE CIRCLE: TO / FROM: **Vitae Integrative Medical Center**
2925 Debarr Rd. Suite 150
Anchorage, AK 99508

PLEASE CIRCLE: TO / FROM: Medical Facility or Provider:_____
Address:_____
Phone Number: _____
Fax Number: _____

Information to be released:	**Dates:**
☐ All Records ☐ Chart/Visit Notes ☐ Lab Results ☐ Imaging/Radiology ☐ Billing Statements	☐ Most Recent *(preferred)* ☐ Last 2 years ☐ ALL RECORDS ☐ Other *(please specify):*_____

_____ **Reciprocal Authorization for Release of Information (check if applicable/authorizing): this authorization allows Vitae Integrative Medical Center to have continuous dialogue between clinical personnel of Vitae Integrative Medical Center and the entity identified above. This authorizes full disclosure of the patient's medical records, psychotherapy notes, recommendations for further care, and names of health care personnel, dates of hospitalizations, charges, and visits. All records are kept confidential and shared only with pertinent personnel involved. I understand that this Reciprocal Authorization expires one-year (365 days) from the date it is signed by a patient/legal guardian.**

I acknowledge the information to be released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus(HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time by giving written notice to VITAE I.M.C. I understand the revocation will not apply to information that has already been released in response to this authorization, and the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. In the absence of a revocation this specific authorization expires one year from the date of signature. I understand once the above information is disclosed, it may be redisclosed by the recipient and that the released information may not be further protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to obtain healthcare treatment.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Name of Legal Representative *(if applicable)* Relationship to Patient *(if applicable)*