THRIVE INTEGRATIVE MEDICINE, LLC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(*This authorization complies with HIPAA)*

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize Thrive Integrative Medicine LLC to**:** ☐ **Release** or ☐ **Request my health information as identified below to:**

Person/Physician/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from _____ to _____ may be released:

☐ Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.

☐ Lab Results

☐ Imaging Results

☐ Chart Notes ☐ Other:_____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Description of Personal Representative's Authority: