Medical Records Release and Authorization
For Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____

SSN: _____ Date of Birth:____/____/____

I authorize the custodian of records of: _____

to disclose/release the following information* **(Enter name of physician or practice fax number & phone)**

For records related to a specific condition only: _____
(Enter condition or leave blank for all records)

☒ All records ☐ Abstract/Summary ☐ Office Notes – Diagnosis and Treatments Including Med List
☐ Psychiatric ☐ HIV/AIDS ☐ Drug/Alcohol Abuse ☐ Laboratory/pathology records
☐ Pharmacy/prescription records ☐ X-ray/radiology records ☐ Billing records

***Note:** By checking above you are hereby authorizing disclosure of this information.*

☐ Transferring Care ☐ Consultation

☐ All dates
☐ These records are for services provided on the following date(s): _____
Please send the records listed above to

Integr8 Health
964 Western Ave #1
Manchester, ME 04351
Phone 207-512-8633
Fax (888) 688-0407

and/or

Name: _____
Address: _____
_____
Phone _____
Fax: _____

This authorization shall expire no later than: ___/___/___
or one year from the date of signature if left blank.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____
Signature of patient (or patient's personal representative)

_____
Date

_____
Printed name of patient representative

_____
Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor)*
You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the custodian of records listed above.