THE HARVEY CENTER FOR INTEGRATIVE MEDICINE

Innovative solutions for optimal health & vibrant energy

AUTHORIZATION TO RELEASE RECORDS

Date _____

I request that my medical records be released to:

Name: _____

Address: _____

_____

Phone: _____ Fax _____

Patient _____ Date of Birth _____

SS# _____ Signature _____

Protective or sensitive information: I understand that certain information cannot be released without specific authorization required by State/Federal law. By INITALING I authorize the release of the following protected or sensitive information.

_____ Drug Abuse Diagnosis/Treatment

_____ Sexually Transmitted Disease

_____ AIDS/HIV Test Results Including High Risk Behavior

_____ Genetic Testing

_____ Alcoholism Diagnosis/Treatment

_____ Mental Health/Treatment

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. The information may be redisclosed if the recipient is not required by law to protect the privacy of this information.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary; to other physicians you may be treating you. Your protected health information may also be provided to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose and treat you. In addition, we may disclose your protected health information from time-to-time to another healthcare provider (laboratory, imaging center, surgery center or hospital) who, at the request of you physician, becomes involved in your care.

Payment: Your protected health information may also be used to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you. For example, obtaining approval for surgical procedures or hospital admission may require that your relevant protected health information be disclosed to your health plan to obtain approval.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of this practice. These activities include quality assessment, employee training and reviews, and conducting daily operations. Daily operations include signing in on the iPad at the registration desk where you will be asked to verify your information, calling your name in the waiting room for your appointment and to contact you by telephone to remind you of an appointment. We may share your protected health information with third party "business associate" who perform various activities (**billing, collections and computer programming**) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.