AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Integrative Family Medicine of Connecticut (IFMCT) to disclose my individually identifiable health information as described below. I understand that this authorization will expire 180 days from the date of signature, or at the date or event specified here: ____.

I further understand that I may revoke this authorization at any time by notifying IFMCT in writing. The revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations. IFMCT will make every reasonable effort to ensure that my information is transmitted securely, however I understand that certain methods of delivery are not to be considered secure. I have selected the delivery method below with full knowledge of this information.

Patient Name: ____

Date of Birth: ____/____/_________

Please release information from the following IFMCT physicians (check all that apply):

☐ **Dr. Michael Geis, DO** ☐ **Dr. Minna Kim, ND** ☐ **Dr. Sylvia Cimoch, ND**

The information will be released to:

☐ **Patient/Designee** ☐ **Health Care Provider** ☐ **Insurance** ☐ **Attorney** ☐ **Other**

If other, please specify: ____

Individual/Organization Name	Telephone Number	Fax Number
Street Address	**City, State, Zip**	

Record copy delivery method:

☐ **Pick-up** ☐ **Mail** ☐ **Fax** ☐ **OnPatient Portal**

Please release information for these treatment dates: ____

Information to be released (check all that apply):

☐ **Encounter record** ☐ **Billing record** ☐ **Lab results** ☐ **Supplements** ☐ **Other**

If other, please specify: ____

I understand the record(s) requested may not be complete if it is a recent visit, and additional documentation may be added after submitting this request. I further understand there may be a charge for records provided, as permitted by Connecticut law.

____ ____

Signature of Patient or Legal Representative **Date**

____ ____

Printed Name of Patient or Legal Representative **Relationship to Patient**