Southwick Integrative Healing

A BALANCED APPROACH TO YOUR HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

First Name:	Middle Name:	
Last Name:		
Street Address:		
City:	State:	Zip:
Phone Number:	Birthdate (mm/dd/yyyy):	

I, _____ authorize _____
(Patient's full name) (Provider/Practice name)

To release the following medical information to: _____

For the following purpose:_____ .

Please initial the appropriate box:

☐ All of my medical record (as of the date of this release)

☐ All of my medical record except the following:_____

☐ Only the following information: _____

I acknowledge and hereby consent such, the released information may contain alcohol, drug abuse, psychiatric, HIV testing/information. I understand that I may revoke this consent at any time with the exception of records that have already been released. If the requestor is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

Printed Name:_____ Relationship to the Patient: _____

Signature:_____ Date: _____

☐ Please fax records to Southwick Integrative Healing at 866-817-1629

☐ Please fax records to _____ at _____

If you receive part of this transmission, or if transmission is illegible, please call 801-432-7712.

CONFIDENTIALITY NOTICE: This information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material in error, please contact the sender and delete or destroy the material.