FULL SPECTRUM
INTEGRATIVE MEDICINE
For Optimal Health & Wellness

Medical Release Form

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of medical records. Covered entities, as that term is defined by HIPAA and relevant state law, must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's PHI. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law.

Information regarding the patient for whom the authorization is made:

Patient Name:_____Date of Birth:_____
Address: _____Contact phone:_____
Email: _____

Release my information: ____**from** _XX_**to**

Full Spectrum Integrative Medicine
216 Mall Blvd., Suite 110
King of Prussia, PA 19406
P: 610-557-8500
F: (610) 320-2025

Release my information: X from_____ **to**

Facility/Physician Name: Marcus Institute for Integrative Health_____
Address: 789 E. Lancaster Ave, Suite 110_____
City: Villanova_____State: PA_____ Zip: 19085
Contact Phone: 215-503-9070_____Contact Fax: _____610-527-1950

REASON FOR DISCLOSURE

___Treatment/Cont. Medical Care ___Personal Use ___Billing or Claims

___Insurance Legal Purposes ___Disability Determination____School Employment

____Other

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items the information that you want disclosed. **If all health information is to be released, then check only the first item**.

___All Health Information
___Medical Progress Notes
___Pathology Reports
___History/Physical Exam
___Patient Allergies
___Lab Results
___Discharge Summary
___Billing Information
___Past/Present Medications
___Operation Reports Diagnostic Test
___Reports Radiology Reports & Images
___Consultation Reports EKG/Cardiology Reports Other

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Your initials are required to release the following information:
___Mental Health Records (excluding psychotherapy notes)
___Drug, Alcohol, or Substance Abuse Records
___Genetic Information (including Genetic Test Results)
___HIV/AIDS Test Results/Treatment

The individual signing this form agrees and acknowledges as follows:

i. Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will NOT be conditioned upon my signing of this authorization form.

ii. Effective Time Period: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): _____

iii. Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

iv. Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION ONLY if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

v. Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: _____ Date:_____

Name:_____