Sarma Integrative Medicine
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Authorized Use or Disclosure of Medical Information

I authorize the following using or disclosing party:

_____

To use or disclose the following health information: (check one)

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

The above party may disclose this health information to the following recipient:

Name (or title) and organization

_____

Address

_____

City _____ State _____ Zip _____

Phone _____ Fax _____

This authorization ends: (date)

Name and Signature of Patient: _____ Date: _____

<u>If the patient is unable to sign, please complete the following</u>:

☐ - Patient is unable to sign because: _____

Name and Signature of Authorized Representative:

_____

Date: _____

Additional Consent for Certain Conditions

This medical record may contain information about AIDS/ HIV, physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Name and Signature of Patient or Authorized Representative:

_____

Date: _____