INTEGRAL HEALTH ASSOCIATES

437 Orange Street, New Haven, CT 06511 Tel (203) 909-6370, Fax (203) 909-6374, Alt Fax (203) 777-6776

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize Integral Health Associates to release and obtain protected information regarding the above named person as indicated below to and from:

Name of person or organization: _____
Address: _____
Phone: _____ Fax: _____

This authorization applies only to the following protected health care information:

- ❑ All pertinent health care information
- ❑ Summary of treatment, including diagnosis
- ❑ Diagnoses, dates of service, and procedures
- ❑ Other (specify): _____
- ❑ HIV related information
- ❑ Labwork
- ❑ Alcohol and/or drug treatment records

During the time period or date(s): ❑ All _____

For the following purpose(s):

- ❑ Continuing Care/Treatment Planning
- ❑ Medical Leave/Accommodation
- ❑ Other (specify): _____
- ❑ Insurance
- ❑ Legal

- I understand that the information released may contain health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment.
- I understand that signing this authorization is voluntary.
- I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.
- I understand that I may revoke this authorization at any time by making a written instruction to Integral Health Associates.
- A photocopy or facsimile of this form will be considered as valid as the original.

This authorization will…

- ❑ remain in effect as long as I am a patient in the care of Integral Health Associates.
- ❑ expire one year from the date signed.
- ❑ expire on _____

_____ _____
Signature of Patient/Authorized Guardian Date