Salveo Integrative Health

AUTHORIZATION TO RELEASE INFORMATION

_____ _____ _____ _____
Name of Patient (at time of service) DOB Social Security Number

This release will include DRUG and ALCOHOL history, treatment and/or diagnosis unless specifically excluded. I authorize Salveo Integrative Health and its clinical and professional staff to:

_____ Release information to the following:
_____ Receive information from the following:
_____ Exchange information with the following:

_____
Name/Title/Facility

_____
Street Address, City, State, ZIP

_____ _____
Phone Number Fax Number

Specifically requested records consent: _____ Discharge Summary
_____ Psychiatry / Therapist evaluation
_____ Medical information
_____ Other information_____

Record information **NOT** to be released:
_____

The purpose of this release: _____ Insurance / 3rd party payment _____ Pending legal action
_____ Continuity of care _____ Assist in evaluation
_____ other, specify: _____

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Salveo Integrative Health nor health care benefits. This authorization shall expire 1 year or _____ from the date of signing, and is subject to revocation by the patient at any time prior to the expiration date, but not made retroactive to any information already released. The request to retract this release shall be in writing, signed, dated and sent to Salveo Integrative Health. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected. I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release.

Signature of Patient: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

Copies of records or reports may be subject to reasonable cost: _____ *Initials*