integrative minds™

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the results of tests, procedures, medication refills, medical and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, prescription refill requests, and/or financial information released and discussed to any family members you must sign this form.
**You have the right to revoke this consent, in writing, except in cases where we have already made disclosures under your prior consent.*

I authorize Integrative Minds, PLC to release my records and any information requested to the following individual(s):

1. Name: _____ Relation to Patient: _____
2. Name: _____ Relation to Patient: _____
3. Name: _____ Relation to Patient: _____
4. Name: _____ Relation to Patient: _____

Authorization Regarding Phone/Text/Email Messages
(please check all that apply)

_____ I authorize Integrative Minds, PLC to leave a detailed message on my home or cell phone via voicemail or via text message regarding appointments.

_____I authorize Integrative Minds, PLC to leave a detailed message on my home or cell phone via voicemail or via text message regarding medical treatment, care, test results, or financial information.

_____ I authorize Integrative Minds, PLC to leave a message with anyone who answers the phone at my primary number listed on file.

_____ Messages may ONLY be left with (name of individual) _____

_____ _____
Patient Name (Print) Date of Birth

_____ _____
Patient Signature Date

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