Authorization for the Release of Information

I, the patient, hereby authorize the use or disclosure of my health information from the listed health practitioner as described below to the requesting practitioner.

Patient Information

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ Social Security Number _____

Health Practitioner
Health Practitioner Name _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ Fax Number _____

I authorize for _____[practitioner name] to release and/or disclose the medical information as indicated below to the healthcare provider, entity, or person I have indicated above.

DURATION: This authorization shall become effective immediately and shall remain in effect until _____[date], or for 1 year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Check the box and initial which type of information is to be released and/or disclosed.
_____ General medical information from _____ to _____ (dates)
_____ Laboratory tests (serum, urine) from _____ to _____
_____ Information regarding specific diagnosis or treatment from _____ to _____.
_____ Other (nutrition, dental)_____

Requesting Practitioner Information
Zorayda J. Torres, M.D.
27499 Riverview Center Blvd., Suite 255
Bonita Springs, FL 34134
Ph: (239) 444-5636
Fax: 1-888-977-2954

Patient Name (printed): _____

_____ _____
Signature of Patient Date

ALL PATIENT INFORMATION IS HANDLED UNDER THE HIPPA PRIVACY ACT
CONFIDENTIAL / HIPPA-Approved Form

IFM
THE INSTITUTE FOR FUNCTIONAL MEDICINE