Natura Medica

THE CENTER FOR NATURAL MEDICINE

Authorization to REVIEW or OBTAIN COPIES of Medical Records (page 1 of 2)

I, _____(print name), hereby authorize Integrative Wellness Center, LLC dba Natura Medica to obtain /receive the medical records of _____(print name of patient), _____(patient's Date of birth).

The records should be ☐ **RELEASED TO/** ☐ **OBTAINED FROM**:

NAME: _____

ADDRESS: _____

PHONE/FAX: _____

Information to Disclose:

I request that the information to be used or disclosed consist of the following (if this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information.)

Method of Disclosure: O Mail O Pick-up O Fax **(IF more than 25 pages, please MAIL correspondence)**

☐ I understand that sensitive information regarding HIV/AIDS, or treatment for substance abuse (alcoholism or drug abuse) and /or mental health issues may be disclosed ☐ I Authorize ☐ I DO NOT Authorize

Check all that apply:

☐ Laboratory reports (blood tests, biopsies, culture, and other reports) _____ (months, years, dates)
☐ Diagnostic Imaging (X-ray, MRI, CT, US, DEXA, ECG, and other reports) _____ (months, years, dates)
☐ Immunization Records
☐ Emergency Department Report, including labs and imaging_____ (months, years, dates)
☐ Other (specify):_____ (months, years, dates)
☐ Only medical records from Natura Medica providers _____(dates)
☐ Complete medical record (including records from prior providers)

Purpose of use/disclosure: It is my understanding that the information to be USED or DISCLOSED will be used for the following purposes:

Check all that apply:

☐ At the request of the individual signing this authorization. ☐ Legal investigation or action
☐ Additional medical care ☐ Insurance eligibility / benefits ☐ Change of provider
☐ Other (specify): _____

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REDISCLOSURE: I understand that the disclosed information may be redisclosed in accordance with law and may no longer be protected by privacy requirements. Further, I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standard, the information disclosed pursuant to this authorization may no longer be protected. However, other state or federal law may prohibit the recipient from disclosing specially protected information, e.g., substance abuse treatment information, HIV/AIDS-related information, and mental health information.

INDIVIDUAL'S RIGHTS: I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that Integrative Wellness Center, LLC dba Natura Medica may not condition treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying Natura Medica in writing of my revocation. To revoke or to receive a copy of my revocation, contact Natura Medica office manager, 12 Roosevelt Ave, Mystic, CT 06355. Attn: office manager/privacy official. I am aware that my revocation will not be effective until received by Natura Medica and will not affect uses and/or disclosures prior to its receipt.

ALTERATION: This authorization may not be altered in any manner. If altered, in the sole discretion of Natura Medica it may be considered void and of no effect.

****NOTE:** ***There is a 65-cent per page copying charge, plus postage, generally allowable, under Connecticut State Law****

EXPIRATION DATE: This Authorization is valid for one year from the date signed unless otherwise specified here:_____

PRINTED NAME: _____ DATE: _____

SIGNATURE: _____

Circle one: Patient / Parent / Health Care Representative*/ Executor*/ Administrator*

Attach a copy of appropriate documentation as Health Care Representative, Executor, OR Administrator

**OFFICE USE ONLY: CODE as IWC _____

*COPY OF APPROPRIATE DOCUMENTATION ATTACHED _____

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