IMA
INTEGRATED MEDICINE ALLIANCE

PO Box 8519
Red Bank, NJ 07701

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

- ☐ Myself only
- ☐ My spouse/significant other (specify name) _____ contact # _____
- ☐ My parent(s) (specify name) _____ contact # _____
- ☐ Other (specify name) _____ contact # _____

Information to be disclosed: ☐ All Information

- ☐ Laboratory results
- ☐ X-Ray results/film
- ☐ Diagnosis
- ☐ Medications
- ☐ Immunizations
- ☐ Other test results (specify) _____
- ☐ Other _____
- ☐ Dates of service _____

This protected health information is being used or disclosed for the following purposes:

- ☐ At the request of myself
- ☐ Other _____

I would like to be contacted at my:

- ☐ Home phone _____
- ☐ Cell phone _____
- ☐ Other _____
- ☐ Work phone _____
- ☐ Mail _____

Regarding the office staff or physician leaving information or confirming appointments on my answering machine, voicemail or with my answering service?

- ☐ Yes, I give my permission for non-medical information and appointment reminders to be left on my answering systems
- ☐ Yes, I give my permission for medical information to be left on my answering systems
- ☐ No, I do not want messages or medical information left on my answering systems

This authorization shall be in force and effect until revoked at which time this is authorization expires.

I understand that I have the right to revoke this authorization, in writing, or at any time by sending such written notification to the Privacy Officer at the above address. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or state law.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Patient or Personal Representative

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Integrated Medicine Alliance's Notice

_____ _____

Signature of Patient or Personal Representative Date