| AUTHORIZATION TO RELEASE INFORMATION | | | |
| --- | --- | --- | --- |
| Patient name: | | Date of birth: | |
| Doctor/Facility Name: | | | |
| Address: | | | |
|  | | | |
| I hereby authorize this practice to make use and disclosure of my protected health information (information about me in my medical records and/or financial records) as indicated below. | | | |
| This information is to be disclosed to:  **Green Health Collective**  **270 Amity Road Ste 132**  **Woodbridge, CT, 06525**  **Phone:203-318-6143 Fax: 855-576-3507** | | | |
| Description of information to be disclosed: Medical Records | | | |
| Reason for the requested use of disclosure: Patient Care | | | |
| TO BE READ AND SIGNED BY PATIENT: | | | |
| I understand the following:   1. I may revoke this authorization at any time by providing written notice to the practice. 2. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage. 3. The practice will not condition treatment or payment based on my signing this authorization. 4. I am signing this authorization freely. 5. No one has pressured me to sign this authorization. 6. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by law. 7. I acknowledge that I have had opportunity to review this authorization and understand the intent and the use. 8. I have received a copy of this authorization. | | | |
| Patient signature: | | | Date: |
| Signature of patient’s representative: | Relationship to patient: | | Date: |
| FOR OFFICE USE ONLY | | | |
| Event or date upon which authorization will expire | | | |