| AUTHORIZATION TO RELEASE INFORMATION |
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| 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.
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| Patient signature: | Date: |
| Signature of patient’s representative: | Relationship to patient: | Date: |
| FOR OFFICE USE ONLY |
| Event or date upon which authorization will expire |