THE CENTER FOR NATURAL & INTEGRATIVE MEDICINE

KIRTI M. KALIDAS M.D., N.D.

Board Certified Internal Medicine & Naturopathic Medicine

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: ____ Social Security #:________________________

Address: ____

Date of Birth: _____/_____/_____ Date of Service: _______________________Phone #:_______________________

Identification Shown: _______________________________________ Mail ☐ Pick Up ☐

I hereby authorize The Center for Natural & Integrative Medicine to: ☐ **disclose to** ☐ **obtain from**

____ ______________________________________

Name of Facility or Person Phone #

____

Fax #

____

Street Address City State Zip Code

***In order to maintain legibility of records, please MAIL records unless otherwise requested.**

The following information contained in my medical record regarding my care and treatment (please initial):

_____ **Complete Record**

_____ **Progress Note(s)** ___________ Dates

_____ **All Diagnostic Test Results** ___________Dates

_____ **Lab Only** ___________Dates

_____ **Other (Please Specify)** ____

The purpose for the release of information at the request of the individual is:

☐ Continued Treatment ☐ Insurance ☐ Legal Action ☐ Personal Use (**release to patient prepay charge up to $1/page plus handling**)

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initiated below or otherwise required by law.

May **NOT** include information related to (please initial):

_____HIV/AIDS ____Mental Health ____Drug and/or Alcohol Abuse ____Genetic Counseling/Testing Information

***This authorization is in effect for (1) year or until I revoke it in writing**. I understand that I may revoke this authorization at anytime. I also understand that records released prior to any written notice of revocation to do this I must do so in writing to:

Anita Kalidas, Office Manager 6651 Vineland Road Suite 150, Orlando, FL 32819

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above maybe disclosed to other individuals or institutions and no longer protected by these regulations.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in anyway on whether I sign this authorization. I understand that I have the right to inspect any information disclosed.

I hereby release The Center for Natural & Integrative Medicine and its employees from any and all liability that may arise from the release of the information as I have directed.

I understand that I may be charged up to $1 per page (plus handling) for every page. This fee is waived for copies provided to a healthcare provider for continuing medical care. I understand that this fee is within the allowable Florida law.

I hereby authorize **The Center for Natural & Integrative Medicine** to **OBTAIN** or **RELEASE** as described above.

Patient Sign____Date________/_______/__________

Witness ____Date_______/_______/__________

Office Use Only: ____

☐ Name of Person Releasing Information ☐ Name of Person Assisting with Review Number of pages copied: ____________