INTEGRATIVE MEDICAL CLINIC
of North Carolina

Member Information (person whose information will be released)

Your name:_____ Date of Birth:_____

Address:_____

Phone #: _____ Email: _____

I understand that this authorization will allow Integrative Medical Clinic of North Carolina to disclose the protected health information described below: (Please only select ONE statement)**

- Any and all protected health information Integrative Medical Clinic of North Carolina maintains, including mental health, HIV, health status or substance abuse records.

- Protected health information about treatment for the following condition or injury OR other information (include dates)._____

This information can be disclosed to, and used by, the following people, organization or caregiver:

Name:_____ Date of Birth:_____

Address:_____

Relationship: _____

This information is being disclosed to allow the person named above to assist me with my treatment plan.

I understand that he/she may receive communications from IMCNC tailored to my specific conditions or health needs, to help manage my health and wellness. I understand I have the right to revoke this authorization at any time by sending written revocation to IMCNC. I understand the revocation will not apply to information that has been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 24 months.

I understand I do not have to sign this authorization and that IMCNC cannot base treatment decisions on whether I sign this authorization. I understand that after the information is disclosed pursuant to this authorization, it can be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

Patient or Legal Representative Signature: _____ Date: _____

*Health includes Medical, Prescription, Behavorial Health, Long-Term Care