MOUNTAIN INTEGRATIVE MEDICINE, PLLC
Danna Park, MD, FAAP, FACP

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# AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize _____ to disclose the following information from the medical records of:

Disclosing Practice/ Provider'sName_____PhoneNumber_____

Address_____Fax Number_____

This information is to be disclosed to the following individual or entity for the purpose of: Integrative Medicine Consultation

Provider: Danna Park, MD, Mountain Integrative Medicine, PLLC
Address: 138 Charlotte Street, Suite 203, Asheville, NC 28801
Phone: 828-333-3339
Fax: 828-254-3114

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

Covering the period(s) of health care:
From _____ to _____

From _____ to _____

Information to be disclosed:
☐ Complete health record(s), including all images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all images
**OR**
Select from the following (check as many as apply):

☐ Discharge Summary
☐ History and Physical Examination
☐ Progress Notes
☐ Laboratory Tests

☐ Consultation Reports
☐ Mental health care or services
☐ Treatment for alcohol and/or drug abuse
☐ X-ray reports
☐ Psychotherapy Notes

☐ Other (please specify) _____

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on __/__/__ or on the happening of _____.
Initials: _____

b. I understand that I may revoke this authorization at any time by notifying the above in writing, but if I do it won't have any effect on any actions the disclosing practice/physician took before it received the revocation.
Initials: _____

c. I understand that the disclosing practice/physician cannot make me sign this authorization as a condition to receive treatment from the disclosing practice/physician except:

(i) when the disclosing practice/physician provides me with research-related treatment; or

(ii) when the disclosing practice/physician provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
Initials: _____

The disclosing practice above, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**(*Form MUST be completed before signing*)**

_____
Signature of Patient or Representative

_____
Date

_____
Print Name

_____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

_____

_____