SATORI INTEGRATIVE MEDICINE CLINIC

RELEASE OF INFORMATION

General Information Regarding This Authorization: This Authorization permits Satori Integrative Medicine Clinic to use or disclose your Protected Health Information for purposes other than your treatment or payment to Satori Integrative Medicine Clinic or the health care operations of Satori Integrative Medicine Clinic. You have the right to revoke this Authorization by providing Satori Integrative Medicine Clinic with written notice of revocation. The revocation will be effective upon receipt by Satori Integrative Medicine Clinic except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization.

Satori Integrative Medicine Clinic cannot require you to sign this Authorization as a condition to the provision of services. Please note that once the requested information is disclosed pursuant to this Authorization, Satori Integrative Medicine Clinic will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient.

AUTHORIZATION: I hereby authorize Satori Integrative Medicine Clinic to use or to disclose, by any acceptable means, my Protected Health Information described as follows:

Please check all boxes that apply:

☐ **Assessment** ☐ **Treatment Information** ☐ **Psychotherapy Notes** ☐ **Other Information**

Please write in other information below:

To the following persons or class of persons (include name, address and telephone number):

The purpose of this requested use or disclosure is:

This Authorization shall expire on ___/____/20 ___ , which is not more than one year after its effective date, unless it is revoked prior to the expiration date.

Patient or Legal Representative

Print: First Name ________________________ Last Name ______________________________

Signature: ____ Date __________

Last updated 04/13/2020