REQUEST AND AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, hereby give my consent and authorization to:

Osteopathic Integrative Medicine
9600 W. Jewell Ave., Suite 3
Lakewood, CO 80232
Phone: 303-350-7990 Fax: 303-217-5708

To release the following information:____

____

____

From records during my treatment from ______________________ to ____________________________

To.____

____
(name and address of party to release information)

My signature acknowledges that:
I have read the authorization or have had it read to me.
I understand and agree to its contents.
I have been informed that no other information may be released without my written consent.
I have been informed that I may revoke this authorization by written statement at any time.
The party releasing the information is released from any liability that could result from the release of the requested information.

Print Name:__________________________________ ____
(patient or authorized party) (patient /date of birth)

Signature:_______________________________________ Date:_____________________________________

____
(relationship to patient)