Ark Integrative Medicine
www.ark-imed.com

ARK INTEGRATIVE MEDICINE

Patient's Consent for Request and Release of Medical Records from Current Provider

LAST NAME ______ FIRST NAME ______ DATE OF BIRTH ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______

PHONE ______ EMAIL ______

I, (patient's name) ______ hereby authorize (health provider's name) ______

with a business address of (health provider's address) ______

with a telephone number of (health provider's phone number) ______ to provide my medical records and pertinent health information to **Ark Integrative Medicine** for the purpose of initiating or continuing treatment with Ark Integrative Medicine. This consent for the release of my medical information shall remain valid until this end date (specify an End Date; MM/DD/YYYY) ______.

I understand that areas of my medical record *including information pertaining to mental health, drug and/or alcohol abuse will be included unless I specify that the following areas are not to be released below:*

I understand that I have a right to receive a copy of this request.

TODAY'S DATE (MM/DD/YYYY) ______ **SIGNATURE** ______

Ark Integrative Medicine 15785 Laguna Canyon Rd Ste. 125 Irvine, CA 92618
(949) 932-0350 Fax: (833) 594-2272 Email: irvine@ark-imed.com