GhentMD
INTEGRATIVE HEALTH & WELLNESS CLINIC

AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION (HIPPA)

Patient Name _____ **Date of Birth**_____

1) Please check (√) one only:

☐ I only want my medical information released to myself.

☐ I give GhentMD Integrative Health & Wellness Clinic and staff authority to release medical information regarding my care to the following individuals:

Individuals Name:	**Relationship to Patient:**
_____	_____
_____	_____
_____	_____

Patient Signature _____ **Date** _____

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NOTE: The above authorization remains effective until patient notifies practice in writing of any change.

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