

**Montague Integrative Health
Valley Naturopathic Family Medicine**

Dr. Emily Maiella N.D.
432 Greenfield Road, Montague MA 01351
1063 Marlboro Road, Brattleboro VT 05301

Authorization to Release Confidential Health Information

I Hereby Authorize:

- Practitioner's name:
 Facility/Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip: _____ - _____
Phone#: _____ Fax #: _____

To Release:

- Complete Chart Record (*does not include billing information or radiographic images*)
 Chart Notes: All Specify: _____
 Labs/Reports: All Specify: _____
 X-rays/Radiographic Images(specify): _____
 Other: _____

From the Health Records of:

Name: _____ Date of Birth: ____/____/____
Soc. Sec. Number: _____ Daytime Phone: _____ ext.: _____
Are you authorizing release of your own records? Yes No

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

To be Released to:

- Facility/Doctor:** Montague Integrative Health/Dr. Emily Maiella ND
Address: 432 Greenfield Road
City: Montague **State:** MA **Zip:** 01351
Phone #: 413.367.9350 **Fax #:** 413.367.9355

For the Purpose of:

- Adjunctive/Concurrent Care Transfer of Care Other:

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document..

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to:

(check the accompanying box(s) below to EXCLUDE the information from authorization)

- substance abuse mental health/psychotherapy notes sexually transmitted diseases and HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call Dr. Maiella to inquire about revoking this authorization.

RECOMMENDATION: Include a statement about any fees associated with obtaining copies of records.

Guardian/Personal Representative's Name (PRINT)

Patient's Name (PRINT)

Guardian/Personal Representative's Signature

Patient's Signature

Relationship/Representative's Authority

Date