Patient Name: _____ Date of Birth:__/_____/____ Date of request_____
Address:_____
City: _____State: _____ Zip Code: _____Phone #: (_____)_____-_____

To be delivered by HIPAA-secure email _____ (initials) OR
To be delivered by FAX _____ (initials)
Fax number to which to send records: (_____) _____-_____

**I AM REQUESTING TO RECEIVE MY MEDICAL RECORDS FROM:**
Riobe Institute of Integrative Medicine
Address: 304 Tequesta Drive. Suite 300
Jupiter, FL 33469

FOR THE FOLLOWING DATES _____/_____/_____ TO _____/_____/_____

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for:
____Medical Notes; ____Lab Results; _____ Procedure Notes;
Reason for requesting information: _continuation of care

THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Riobe Institute of Integrative Medicine. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days). If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or released, as provided in CFR 164.524. I understand that any release of information carries with it the potential for an unauthorized re-release and the information may not be protected by Federal confidentiality rules. If I have questions about release of my health information, I can contact the authorized individual or organization making disclosure.

PATIENT SIGNATURE _____

Printed patient name _____ Date of Birth ____/ _____/ _____