Sally Boyd-Daughtrey ND, Christopher Lawinski, MD
Vitality Integrative Medicine
Authorization for the Release of Information

Patient Information
Name _____ Date of Birth _____

This Authorizes:
Health Practitioner Name _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ Fax Number _____

To Release Information to:
Health Practitioner Name ___Christopher Lawinski_____
Address __15-3039 Pahoa Village Rd. __ City __Pahoa_____ State __Hi___ Zip Code __96778____
Phone _(808)443-2633_____ Fax Number _(808)965-2082_____

Each of the following applicable items must be dated and initialed prior to their release, in accordance with Federal Regulations 42 CFR Part 2.
I hereby consent to the release of records pertaining to:
• Conditions related to drug and/or alcohol abuse. Initial and Date_____
• Conditions related to psychiatric/psychologic treatment. Initial and Date_____
• Acquired Immune Deficiency Syndrome (AIDS) Initial and Date_____

Check the box and initial which type of information is to be released and/or disclosed:
• _☐_ General medical information, records, progress notes, summaries.
• _☐_ Laboratory tests.
• _☐_ Information regarding specific diagnosis or treatment _____.
• _☐_ Imaging results _____
• _☐_ Other _____

This information is needed for the following purpose:
• _☐_ Continuation of care
• _☐_ Other:_____

DURATION: This authorization shall become effective immediately and shall remain in effect for 1 year from the date of signature.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Patient Name (printed): _____

_____ _____
Signature of Patient Date

ALL PATIENT INFORMATION IS HANDLED UNDER THE HIPPA PRIVACY ACT
CONFIDENTIAL / HIPPA-Approved Form