integrative
medical solutions

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Patient Name: _____ DOB:_____

I, _____, give my permission for my reports and/or appointments to be released to the following individual(s):

Name:	Relationship:	Phone Number(s):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Can we leave information on your voice mail? Yes: _____ No: _____

_____ _____
Patient Signature: Date:

HIPAA Release

I have received a copy of the Notice of Privacy Practices (HIPPA) for Integrative Medical Solutions.

_____ _____
Patient Signature: Date: