

Akasha Center

FOR INTEGRATIVE MEDICINE, LLC.

REQUEST/CONSENT TO RELEASE RECORDS & INFORMATION

I, _____ (print full name), born on _____,
SSN _____, Phone _____

hereby authorize:

Akasha Center for Integrative Medicine, Inc.

520 Arizona Avenue
Santa Monica, CA 90401
Tel (310) 451-8880
Fax (310) 451-8803

To disclose to:

Person or Facility _____

Address _____

Tel _____ Fax _____

The following information:

- | | |
|---|---|
| <input type="checkbox"/> Initial Medical Assessment | <input type="checkbox"/> Drug Screens |
| <input type="checkbox"/> Intake and Discharge Summaries | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Mental Health Evaluation/History |
| <input type="checkbox"/> Treatment/Discharge Plan | <input type="checkbox"/> Complete Medical Record to Date |
| <input type="checkbox"/> Progress in Treatment | <input type="checkbox"/> Other _____ |

For the purpose of:

- | | |
|--|---|
| <input type="checkbox"/> Medical Treatment Plan/Intervention | <input type="checkbox"/> Coordination of Treatment - Referral Source |
| <input type="checkbox"/> Referral of Patient for Further Treatment | <input type="checkbox"/> Coordination of Treatment - Psychiatrist/Therapist |
| <input type="checkbox"/> Other _____ | |

Approximate dates of treatment: _____

Information to be released via: Fax Photocopy/Mail Telephone

****PLEASE allow at least 5 business days for your records****
****Processing fee varies from \$25-\$50 depending on file size****

I understand the purpose of this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implication of their release. This request is entirely voluntary on my part. I am aware that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Print Patient or Parent/Guardian Name Patient or Parent/Guardian Signature Date

I witnessed that the aforementioned person understood the nature of this request/authorization and freely gave his or her consent.

NOTICE: All information contained herein is strictly CONFIDENTIAL and protected from disclosure. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance of the contents of these documents is strictly prohibited.