Akasha Center

FOR INTEGRATIVE MEDICINE, INC.

REQUEST/CONSENT TO RELEASE RECORDS & INFORMATION

I, _____ (*print full name*)**, born on** _____**,**

SSN_____**, Phone** _____**,**

hereby authorize:

*Person or Facility*_____

*Address*_____

_____

*Tel*_____ *Fax* _____

To disclose to:

Akasha Center for Integrative Medicine, Inc.
520 Arizona Avenue
Santa Monica, CA 90401
Tel (310) 451-8880
Fax (310) 451-8803

The following information:

- ☐ Initial Medical Assessment
- ☐ Intake and Discharge Summaries
- ☐ Progress Notes
- ☐ Treatment/Discharge Plan
- ☐ Progress in Treatment
- ☐ Drug Screens
- ☐ Lab Results
- ☐ Mental Health Evaluation/History
- ☐ Complete Medical Record to Date
- ☐ Other _____

For the purpose of:

- ☐ Medical Treatment Plan/Intervention
- ☐ Referral of Patient for Further Treatment
- ☐ Other _____
- ☐ Coordination of Treatment - Referral Source
- ☐ Coordination of Treatment - Psychiatrist/Therapist

Approximate dates of treatment: _____

Information to be released via: ☐ Fax ☐ Photocopy/Mail ☐ Telephone

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.

_____	_____	_____
Print Witness Name	*Witness Signature*	*Date*