Iris
INTEGRATIVE HEALTH
65-1235A Opelo Rd. #6
Kamuela, HI 96743
Ph: (808) 887-1210
Fax: (888) 831-3450

Authorization To Release Confidential Information

Patient's Name:_____Date of Birth:_____

Requesting Provider : ☐ Robert Hollander, MD ☐ Michelle Suber, ND ☐ Stacy Vroman, PA-C

I,_____, herby agree that the provider above may obtain information about me from the following organization(clinic/provider):_____

Address:_____Ph:_____fax:_____

Information Requested(select one):

☐ Entire medical record

! This authorization may include disclosure of information regarding:

☐ alcohol and drug abuse ☐ mental health treatment ☐ confidential HIV related information.

☐ Medical records from date: _____ to date: _____

☐ Specific health information: _____

- This authorization will allow the requesting provider to obtain information from the organization listed above in order to provide quality health-care. It will assist in treatment planning, communication and coordination of care.

-This authorization does NOT allow any of the providers at Iris Integrative Health to discuss health information with anybody OTHER than the organization specified above.

-Information can be shared either verbally, or in writing via fax or regular mail only.

-Signing this authorization is voluntary and will not affect treatment, payment or enrollment in any health plans.

Consent:

This consent has been made voluntarily and without coercion. I was given the opportunity to ask questions and receive answers regarding this authorization. I herby authorize obtaining this information as specified above, and further understand that those who receive this information cannot disclose it to others without any further consent, unless permitted by Federal or State law. I also understand that I may revoke this consent at any time either verbally or in writing.

Patient Signature: _____ Date: _____

Note: White Mountain Health LLC is doing business as Iris integrative Health