Southern Maine Integrative Health Center, LLC
69 York St., Suite 4 Kennebunk, ME 04043 **T** 207-985-3079

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________

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☐ All healthcare information

☐ Other: ____

Please print the telephone number where you want to receive calls about your appointments, labs, and x-ray results, or other health care information if other than your home or work number (such as cell phone number*)
*I am fully aware that a cell phone is not a secure and private line.______________________

Patient Signature: ______________________ Date Signed: ______________________