Main Line Health®
Integrative and Functional Medicine Services

Main Line Health Center in Concordville
1020 Baltimore Pike | Suite 100
Glen Mills, PA 19342

TEL 484.227.7858
FAX 484.227.7877
mainlinehealth.org/integrativemedicine

Authorization for Disclosure of Health Information

I hereby authorize _____to release medical information from the records of:
(Name of Institution)

Patient Name: _____D.O.B: _____SS#:_____

Covering the period(s) of care (list applicable dates of treatment):_____

Information to be disclosed (check all applicable items to be released; for a complete chart copy, place a check in all boxes)

- ☐ Progress notes
- ☐ Medication records
- ☐ History and physical
- ☐ Consultations
- ☐ Operative report
- ☐ X-ray reports
- ☐ Lab reports
- ☐ EKG/ECG tests
- ☐ Therapy notes
- ☐ ER record
- ☐ Discharge summary
- ☐ Discharge instructions
- ☐ Other (please specify):_____

I understand that this will include information relating to (check if applicable to the patient's records):

☐ AIDS/HIV ☐ Psychiatric care/treatment ☐ Treatment for drug or alcohol use/abuse

This information is to be disclosed to:
Main Line Health Integrative and Functional Medicine (Dr. Robert Denitzio)
1020 Baltimore Pike, Suite 100, Glen Mills, PA 19342
Phone: 484.227.7858 Fax: 484.227.7877

For the purpose of (required): Integrative/functional medicine consult

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in six (6) months unless otherwise revoked or indicated to expire on _____ (date not to exceed six months). In accordance with PA state law, I understand that there is a fee for obtaining copies of records, except for copies mailed directly to a health care facility or physician, and I agree to pay such charges.

_____ _____
(Signature of patient or legal representative) (Relationship to patient)

_____ _____
(Signature of witness) (Date)

Verbal release of mental health information:
Verbal consent to release mental health information is acceptable if the patient is physically unable to provide a signature and verbal consent is witnessed by two persons.
We, the undersigned, certify that _____was physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent.

_____ _____ _____ _____
(Witness) (Date) (Witness) (Date)