EVOLUTION
INTEGRATIVE MEDICINE
Life in Balance

PRIVACY PRACTICES - PATIENT RELEASE FORM

I have received or reviewed the privacy practice notice (4 pages) for Evolution Integrative Medicine, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Print the Patient Name

_____

Consent to Treat a Minor: (Guardian Signature)