Integrated Medical Healthcare Services, PLLC
600 Stony Brook Ct
Newburgh, NY
Phone (845) 391-8557
Fax (833) 989-2507

Authorization for Release of Information (Thermography)

Patient Name **Date of Birth**

Street Address **Apt #** **City** **State** **Zip Code**

Phone # **Email Address**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. I have the right to revoke this authorization at any time by writing to the releasing provider. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Unless revoked by written notice, this authorization will expire in one year.
2. Signing this authorization is voluntary. I understand that generally my treatment will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

INFORMATION REQUESTED FROM:

Integrated Medical Healthcare Services, PLLC	845-391-8557
Provider/Group/Entity Name	**Phone #**
600 Stony Brook Ct, Newburgh, NY 12550	833-989-2507
Provider/Group/Entity Address	**Fax #**

SEND INFORMATION TO:

Physician Insights, LLC		
Person/Group/Entity Name	**Phone #**	**Fax #**
5120 South Florida Ave, Lakeland, FL 33813		
Person/Group/Entity Address	**Secure Email Address**	

INFORMATION TO BE DISCLOSED	PURPOSE OF DISCLOSURE
☒ Thermal images & related history	☒ Interpretation of imaging

I hereby authorize the release of health information as indicated above and declare that there is no court order restricting or prohibiting release of the requested records.