SELF
INTEGRATIVE CARE

PHONE 541.482.6777
FAX 541.482.7711

**AUTHORIZATION & CONSENT FOR EVALUATION & EDUCATION**

Functional Medicine Membership

Name: ______________________________ Date of Birth: ________________________

I hereby consent to evaluation and education from Self Integrative Care. This consent represents authorization to release information to laboratories and facilities, as necessary, to order testing and receive results.

I recognize that this information may need to be disclosed, according to my medical condition, for screening, referral, and testing ordered; and may contain information that is protected by federal and state law. I specifically consent to disclosure of such information. I also understand my records may contain drug and alcohol issues which would be released.

**While we will help you to obtain your maximum insurance benefits, the contract of insurance is between you and your insurance company. It is impossible for us to know the details of every insurance plan we encounter. It is your responsibility to know what is and what is not covered by your insurance. You should clarify benfits with your insurer, if they are ever in question. You are ultimately resposnsible for payment of the services we provide.**

___________________________________ ___________________________________

Signature Date