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RELEASE OF MEDICAL RECORDS REQUEST

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Alta Natural Medicine does not reimburse for records received.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____

Physician and Clinic: _____

Clinic Address, phone + fax:_____

Please release the following information:

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information to Alta Natural Medicine. I also authorize the above physician/clinic/hospital to provide the following information to Alta Natural Medicine via verbal and written communication:

_____ All medical records necessary for continuity of care (☐ last ____ years; ☐ all years.)
_____ Laboratory test results and diagnostic imaging with reports only (☐ last ____ years; ☐ all years.)
_____ Other: _____

Patient Signature: _____Date: _____

Parent/Guardian Signature (if applicable): _____Date: _____

Confidential Information:

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information to Alta Natural Medicine. I also authorize the above physician/clinic/hospital to provide the following information to Alta Natural Medicine when necessary:

_____ HIV/AIDS test results, diagnosis, treatment, and related information, including high risk behavior documentation, and other sexually transmitted diseases.
Patient Signature

_____ Drug/alcohol diagnosis, treatment, or referral information.
Patient Signature

_____ Mental Health/ Psychiatric diagnosis, treatment, or referral information
Patient Signature

Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of the above information is to be disclosed. Please provide a description of this information:

_____

_____

For office use only: DATE/TIME FAXED: _____ INITIALS: _____