Request and Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City/State/Zip: _____

- I Give Natural Family Health Permission to **OBTAIN** my medical records from:
- I Give Natural Family Health Permission to **RELEASE** my medical records to:

Facility Name/Provider Name: _____
Address: _____
Phone: _____ Fax: _____
Reason for Transfer: _____

Indicate requested records to be sent or obtained:

____ Health records including chart notes
____ Lab Results
____ Imaging Reports
____ Mental Health Records (must be initialed to be included with other documents)

I understand that this authorization is valid for 6 months from the date of signing unless revoked in writing earlier. The *only exception* is when the action has already occurred as instructed in the consent.

Signature of Patient or Guardian: X _____Date: _____

Relationship to Patient: _____

Katina Martin, ND LAc 111 Maple Street Suite 17, Middlebury VT 05753
P. 802-352-9078
Fax. 802-352-9008