Namaste
Natural Healing Center Inc.
A heart centered approach to healing mind, body, and spirit.

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AUTHORIZATION FOR RELEASE OF RECORDS

I request records from the following Dr. and/or clinic:

Dr. Name: _____

Clinic: _____

Address: _____

City: _____ State: _____ Zip: _____

Please release the following records (initial):	**Please INCLUDE the following (initial):**
_____ All records	_____ Mental Health Records
_____ Chart notes	_____ Communicable diseases includes (HIV/AIDS)
_____ Diagnostic imaging reports	_____ Alcohol/drug abuse treatment
_____ Lab results	_____ Genetic testing
_____ Other _____	_____ Other _____

☐ For all dates of service **OR** ☐ For the following dates only: _____

Requested for the following patient:

Patient Name: _____ Date of Birth: _____

I request copies of the above records to be released to:

_____

_____

_____

_____

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultations, billing or claims payment, or other purposes as I may direct.
- This authorization shall be in force and effect for one year from the date above, at which time this authorization expires.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer had legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I give permission for the above records to be released.

Patient/Guardian Signature: _____ Date: _____