Authorization to Release Patient Health Information

Patient Name _____ _____ _____
Last First M. I.
Medical Record # (if known) _____
Former Name (if any) _____ _____ _____
Last First M.I.
Date of Birth _____/_____/_____
Month Day Year
Daytime Telephone (_____) _____
Social Security # _____

I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED **FROM:**

_____
Organization/Person Name
_____
Street Address
_____
City, State, Zip
_____
Telephone/Fax Number

INFORMATION TO BE RELEASED **TO:**

Dr. Stephen Knight, ND
Natural Health Partners, Inc.
1403 Lomita Blvd., Suite 303-B
Harbor City, California 90710

Phone (310) 988-8403
Fax (310) 634-0389

TYPE OF RECORDS REQUESTED:

I specifically authorize the release of the medical records initialed below, if such records exist:
_____ Transcribed hospital records from the following time period: _____ to: _____
_____ Emergency and urgent care records from the time period: _____ to: _____
_____ Diagnostic imaging reports from the following time period: _____ to: _____
_____ Clinician/office chart notes from the following time period: _____ to: _____
_____ Lab results from the following time period: _____ to: _____
_____ Pathology reports from the following time period: _____ to: _____
_____ Other: _____
_____ Entire medical record

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health information to the above named person or organization.

_____
Date: (mo/day/yr)

_____
Signature of Patient or Authorized Personal Representative
(A minor patient's signature may be required)

_____
Authority to sign, if not the patient