

Records Release Authorization

Willowbend Natural Medicine
Sara Thy, ND

I, _____, DOB: ____/____/____ hereby authorize
(print full legal name) (print date of birth)

to use or disclose the following health information about me:

_____ Complete Copy of Medical Record _____ Office Notes _____ Lab Report
_____ Immunization _____ Growth Chart
_____ Other (describe) _____

I specifically authorize release of my HIV/AIDS results and/or treatment _____ (initial)
I specifically authorize release of psychiatric/neuropsychiatric record _____ (initial)
I specifically authorize release of drug/alcohol abuse/treatment record _____ (initial)
for the following purposes:

_____ at the request or direction of the undersigned individual

_____ Other (describe): _____

The health information described above may be used by or released to:

This Authorization expires:

_____ On the following date: ____/____/____
_____ When the following event occurs: _____

(Patient's signature) (Date) (Time) am/pm (Choose one)

(Witness)

*The above individual is unable to consent because (check one):

_____ Minor
_____ Incompetent
_____ (Other) _____

I therefore consent on behalf of the individual named above.

(Signature) (Relationship) (Date) (Time) am/pm (Choose one)

(Witness Signature)