Records Release Authorization

Willowbend Natural Medicine
Sara Thyr, 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: _____

_____ _____ am/pm
(Patient's signature) (Date) (Time) (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.

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

_____
(Witness Signature)

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