Authorization for Release of Information

Patient Name _____ **Date of Birth** _____

Information to be released from:

Name of Health Care Provider _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Information to be released to:

Lynn Chadd MSN, ARNP / Lynn Chadd Natural Health
PO Box 2124, Poulsbo, WA 98370
Phone 509-548-1801 / Fax 509-548-1879 / lynnchadd.com

Information to be released:

_____ All medical records _____ Last 2 years

_____ Specific information (please specify):

Purpose for which disclosure is being made:

_____ Attorney _____ Insurance _____ Doctor _____ Personal

Patient Authorization: I understand that my records may contain information regarding the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug and /or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. This authorization will expire 90 days from the date signed.

Signature _____ Date _____