Vital Source Natural Medicine

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RELEASE OF MEDICAL RECORDS REQUEST

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care.

Patient Name: _____ **Date of Birth**:_____

********** **Records are to be released from:** **********

Physician and Clinic:_____

Phone: _____ **Fax**_____

********** **Please release the following information**: **********

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information:

_____ All Medical Records Necessary for the Continuity of Care

_____ Labs and Diagnostic Imaging Only

_____ Other: _____

For the time period:

___ Previous ___ months ___ Previous ___ years ___ Entire record

********** **Confidential Information** **********

*I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By **initialing** the spaces below, I specifically authorize the release of the following confidential information to Vital Source Natural Medicine:*

_____ HIV/AIDS test results and related information
Initial

_____ Drug/Alcohol diagnosis, treatment, or referral information
Initial

_____ Mental Health information
Initial

Federal regulations require a description of how much and what kind of the above confidential information is to be disclosed. Please provide a description of this information:

_____

_____

Patient Signature (Parent/Guardian if Minor)**:** _____ **Date:** _____

********** **Please mail or fax as soon as possible to**: **********

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