MEDICAL RECORD RELEASE FORM

Doctor / Hospital: _____

Address: _____

Date: _____

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

☐ Van Harding L.Ac.
10775 Pioneer Trail Suite 212
Truckee, CA 96161

Phone & Fax: 530-536-5084

☐ Me personally and send them to:

_____

_____

Delivery Method: ☐ Mail Copy ☐ Fax ☐ Pick-up In Person
Purpose of Request: ☐ Medical Care ☐ Personal ☐ Continuing Care ☐ Consultation

Information to be released:

☐ Please provide complete copy of my medical history including all diagnostic and laboratory test results.

☐ Please provide complete copy of my diagnostic test results only.

☐ Other: _____

Authorization to Release Protected Information:

☐ I DO ☐ I Do NOT want Mental Health information released. Initials: _____

☐ I DO ☐ I Do NOT want information about HIV Tests & Related information released. Initials: _____

☐ I DO ☐ I Do NOT want information about Alcohol and/or Substance Abuse released. Initials: _____

☐ I DO ☐ I Do NOT want information about Genetic Testing released. Initials: _____

☐ I DO ☐ I Do NOT want information about _____ released. Initials: _____

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

Patient's Signature: _____ Date: _____