Authorization to Release Confidential Health Information

I Hereby Authorize:

___ Mitchell Center for Natural Healing, PLLC
____ Facility/Doctor's Name:____________________
Address:____________________
City:____________________ State:__________ Zip:__________
Phone #:____________________ Fax #:____________________

To Release:

___Complete Chart Record *(does not include billing information or radiographic images)*
____Chart Notes: ____All ____Specify:____________________
____Labs/Reports: ____All ____Specify:____________________
____Billing Records: ____All ____Specify:____________________
____X-rays/Radiographic Images Specify:____________________
____Other:____________________

From The Health Records Of:

Name:____________________ Date of Birth:__________
Daytime Phone #:____________________
Are you authorizing release of your own records? ____Yes ____No
If not, what is your relationship to the patient?____________________

NOTE: Release of certain medical information requires a minor's consent. This includes persons aged 13-17 for information about substance abuse and mental health information, and persons aged 14-17 for information about sexually tranmitted diseases, HIV and AIDS. Other laws may apply.

To Be Released To:

____ Mitchell Center for Natural Healing, PLLC
____ Facility/Doctor's Name:____________________
Address:____________________
City:____________________ State:__________ Zip:__________
Phone #:____________________ Fax #:____________________

For The Purpose Of:

____Adjunctive/Concurrent Care ____Transfer of Care ____Other:____________________

The following specially protected information will be included unless you specify to exclude it. Please check below if you wish to EXCLUDE information about diagnosis, treatment, or referral for the following:
____Substance Abuse ____Mental Health Conditions/Psychotherapy ____Sexually Transmitted Diseases ____HIV/AIDS

This authorization is valid for 90 days from the date signed. I understand that I may revoke this authorization in writing at any time, except to the extent that disclosure has already been made in accordance with this document. I also understand that my healthcare information is protected under federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Patient Signature:____________________ Date:__________
Guardian Signature:____________________ Date:__________