Medical Records Release Form
Authorization for Healing Breeze Naturopathic Clinic to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____ SS#: _____

Address: _____ City: _____ State: ____ Zip Code: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s):_____
- ☐ Other (e.g., X rays, bills), specify date(s):_____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

Please disclose this health care information to:

Name (or title) and organization_____

Address: _____ City _____ State _____ Zip_____

Phone: _____ Fax: _____

Reason(s) for this authorization (check all that apply):

- ☐ at my request
- ☐ other (specify) _____
- ☐ per doctor request

This authorization ends:

- ☐ in 90 days from the date signed
- ☐ on (date) _____ (no longer than 90 days from date signed)
- ☐ when the following event occurs _____ (no longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study

or

- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Healing Breeze Naturopathic Clinic based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature | Date | Time

_____ _____
Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.)