Medical Records Request Form
Authorization to Disclose My Health Care Information to Healing Breeze Naturopathic Clinic

Patient name: _____ Date of birth:_____

Previous name: _____ SS#: _____

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

I. My Authorization: I hereby request and authorize:
Name of Physician or Clinic: _____

Physician Phone #:_____ Physician Fax #:_____
to 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 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:

Healing Breeze Naturopathic Clinic
6119 Old Redwood Highway Ste F Santa Rosa, CA 95403
Phone: (707) 836-1400 Fax: (707) 809-3285

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

- □ at my request
- □ at my doctor's request
- □ other (specify) _____

This authorization ends:

- □ 90 days from the date signed
- □ On this 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. 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 my provider 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.)