NOURISH NATURAL HEALTH CLINIC

Shannon R. May, N.D., L.Ac
Naturopathic Doctor and Acupuncturist

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**:_____
Address: _____ **Phone:** _____

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

Physician and Clinic:_____
Address: _____
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 month ___ Previous 6 months ___ Previous year ___ 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 Nourish Natural Health Clinic LLC:*
_____ 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**: **********
Nourish Natural Health Clinic
1001 E 9th St
Duluth, MN 55805
T: 218.409.4767 F: 612.235.3323