AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

Patient:	Name: ________________________________Home Phone:__________________ Previous name under which chart may be listed: ____________________________ Address: _____________________________ Day Phone:____________________ City:_________________________________ State:______ Zip:________________ Social Security #:_______________________ Date of Birth: ___________________
Health Care Provider:	**Who has information you would like released? "Please fill out completely"** Name: ________________________________ Day Phone:___________________ Address: ______________________________ Fax:__________________________ City:_________________________________ State:_____ Zip:________________
Requested By:	**To Whom should the information be sent?** Stephani Waldron-Trapp, N.D. Natural Family Medicine 232 Central Avenue Osseo MN 55369 Phone: 612-250-2804 Fax: 763-592-8270
Information to be released:	**Please select (X) all the choices that apply:** ___ Complete Medical Records (including Lab and X-ray reports, Patient Education Information, etc.) ___ Other (Specify):____ Records included will be for the last 24 months unless otherwise specified
Reason for Release:	☐ Insurance Change ☐ Second Opinion ☐ Move ☐ Disability ☐ Legal ☐ Other:_________________
Disclosure Statements:	I understand that this authorization will be in effect for 12 months unless cancelled by me in writing. The cancellation will take effect when the provider receives my notice in writing. I understand that signing this authorization is voluntary. I understand that once information is disclosed by Natural Family Medicine, LLC that the disclosed documents may no longer be protected by privacy laws.
Authorization:	I authorize the above provider to release the information marked above to the requestor: Patient Signature: _______________________________ Date:_____________ If other than patient, state relationship and reason patient cannot sign: