

AUTHORIZATION FOR RELEASE 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? Stephani Waldron-Trapp, N.D. Natural Family Medicine 232 Central Avenue Osseo MN 55369 Phone: 612-250-2804 Fax: 763-592-827
Requested By:	To Whom should the information be sent? "Please fill out completely" Name: _____ Day Phone: _____ Address: _____ Fax: _____ City: _____ State: _____ Zip: _____
Information to be released:	Please select (X) all the choices that apply: <input type="checkbox"/> Complete Medical Records (including Lab and X-ray reports, Patient Education Information, etc.) <input type="checkbox"/> Other (Specify): _____ Records included will be for the last 24 months unless otherwise specified
Reason for Release:	<input type="checkbox"/> Insurance Change <input type="checkbox"/> Second Opinion <input type="checkbox"/> Move <input type="checkbox"/> Disability <input type="checkbox"/> Legal <input type="checkbox"/> 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.