California Naturopathic Clinic

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Authorization for Release of Protected Health Information Records

Today's date: _____

Personal Information

First name	Last name	Date of birth
Home address (number and street).		Apt. no.
City, state, and ZIP code.		
Home phone number	Cell phone number	Email address

Physician or Facility Where Patient Records are Held

Physician first name	Physician last name	Facility name
Physician/Facility address (number and street).		Suite. no.
City, state, and ZIP code.		
Physician/Facility phone number	Physician/Facility fax number	Physician/Facility email address

SHADED AREA OFFICE USE ONLY

Type of access requested:

☐ Entire record	☐ Progress notes	☐ Physician's orders	☐ Other: _____
☐ Imaging/radiology	☐ Medication records	☐ ER records	
☐ Operative reports	☐ History and physical	☐ Immunizations	
☐ Laboratory reports	☐ Cardiac studies	☐ Demographics	

By signing below:

- I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results, AIDS information, or sexually transmitted infection/disease information.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- I understand that there may be a fee involved with the fulfillment of this request.
- I understand that the term, entire record, regarding release of protected Health Information means that only records generated by the named facility will be released.
- I authorize the disclosure of the protected health information.
- I authorize release of my protected health information from the physician/facility listed above to:

PLEASE EMAIL RECORDS TO INFO@CALNC.COM (or mail to address at top)

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent's (Guardian's) Name: _____

Parent's (Guardian's) Signature: _____ Date: _____