**Medical Records Release Authorization**

**to Natural Medicine Works**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_, authorize

|  |  |
| --- | --- |
| Name of Doctor |  |
|  |  |
| Health Center |  |
|  |  |
| Address |  |
|  |  |
|  |  |
|  |  |
| Phone | ( ) - |

to release medical information dated \_\_\_\_1-1-2016\_\_\_\_

to \_\_1-1-17\_\_\_\_\_\_\_\_\_\_

Such information to be released:

complete medical records Lab results only

other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail or Fax the forms to:

Dr. Coleen Murphy

Natural Medicine Works

27525 Puerta Real, #100-193

Mission Viejo, CA 92691

Fax 949-229-6217

Such authorization is effective from \_12-1-2016\_\_\_\_\_\_ (mm/dd/yy)

to \_12-31-17\_\_\_\_\_\_\_\_\_ (mm/dd/yy)

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Patient Signature |  | Date |