

Release of Records

I authorize the release of medical information:

TO:

Berkeley Naturopathic Medical Group
2615 Ashby Avenue, Berkeley, CA 94705.
Phone: (510) 845-8600 Fax: (510) 845-5319

FROM:

PROVIDER
ADDRESS
ADDRESS 2
CITY/ STATE/COUNTRY
ZIP
PHONE
FAX
E-MAIL

I specifically authorize the release of the medical records initialed below, if such records exist:

- _____ Transcribed hospital records from the following time period: _____ to: _____
- _____ Emergency and urgent care records from the time period: _____ to: _____
- _____ Diagnostic imaging reports from the following time period: _____ to: _____
- _____ Clinician/office chart notes from the following time period: _____ to: _____
- _____ Lab results from the following time period: _____ to: _____
- _____ Pathology reports from the following time period: _____ to: _____
- _____ Verbal discussion regarding pt welfare and findings from the following time period: _____ to: _____
- _____ Other: _____
- _____ Entire medical record (The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Patient Name

Patient's Date of Birth

Patient/Guardian Signature

Date