EAST BAY
NATUROPATHIC CLINIC
402 Colusa Ave. • El Cerrito, CA 94530 • 510.559.3640

# REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my individually identifiable health information as described below. This authorization is voluntary and valid until revoked by presenting written revocation to East Bay Naturopathic Clinic. I understand that revocation will not apply to information that has already been released in response to this authorization. Records are requested for continuity of care unless otherwise noted.

Patient Name(print)_____ Date of birth_____
Address_____ phone_____

Physician and clinic_____
_____
address_____
phone_____ fax_____

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Please release the following information:

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

_____ All Medical Records Necessary for the Continuity of Care
_____ Labs and Diagnostic Imaging Only
_____ Other: _____

Patient Signature: _____ Date _____
Parent/Guardian Signature (if applicable) _____ Date _____

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Confidential Information:

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information to East Bay Naturopathic Clinic. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

_____ HIV/AIDS test results and related information, including high risk behavior documentation.
patient signature

_____ Drug/Alcohol diagnosis, treatment, or referral information.
patient signature

_____ Mental Health Information
patient signature

Federal Regulation requires a description of how much and what kind of confidential information is to be disclosed.
Please provide a description of this information: _____
_____

Please mail or fax as soon as possible to:
East Bay Naturopathic Clinic
402 Colusa Ave., El Cerrito, CA 94530
phone: 510.559.3640 fax: 510.559.3224
East Bay Naturopathic Clinic does not offer reimbursement for records received.