Willowbend Natural Medicine　　　　　　　　　　　　　　Sara Thyr, ND

Records Release
Authorization

I, ____, DOB: ____/____/____ hereby authorize
(print full legal name)　　　　　　　　　　　　(print date of birth)

____

to use or disclose the following health information about me:

_____ Complete Copy of Medical Record　　_____ Office Notes　　_____ Lab Report
_____ Immunization　　_____ Growth Chart
_____ Other (describe) ____

____

I specifically authorize release of my HIV/AIDS results and/or treatment __________ (initial)
I specifically authorize release of psychiatric/neuropsychiatric record __________ (initial)
I specifically authorize release of drug/alcohol abuse/treatment record __________ (initial)
for the following purposes:

_____ at the request or direction of the undersigned individual
_____ Other (describe): ____

The health information described above may be used by or released to:

____

____

This Authorization expires:
_____ On the following date: _____/_____/_____
_____ When the following event occurs: ____

______________________________________　　______________________________am/pm__
(Patient's signature)　　(Date)　　(Time)　　(Choose one)

____
(Witness)

*The above individual is unable to consent because (check one):

_____ Minor
_____ Incompetent
_____ (Other) ____

____

____

I therefore consent on behalf of the individual named above.

________________________　　________________________　　________________am/pm_
(Signature)　　(Relationship)　　(Date)　　(Time)　　(Choose one)

____
(Witness Signature)

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