RELEASE OF PATIENT INFORMATION

TO: ____
Name of healthcare provider

RE:
Patient Name: ____

Date of Birth: ________________ Social Security Number: ___________________

Street
Address:____

City, State and Zip Code ____

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose my full and complete protected medical information to:

Carolina Clinic of Natural Medicine

150 Preston Executive Dr. #101

Cary, NC 27513

(919) 650-1789 (f)

This disclosure should include: From dates ___________to ___________

Office notes; inpatient, outpatient and emergency room treatments; clinical charts; reports; treatment plans; hospital admission records; discharge summaries and test results.

Laboratory records and specimens; radiology records and films.

Prescription records and drug information related to such records.

Billing records, including statements, insurance claim forms, and statements of benefits for the period ____________ to ______________.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

Signature of Patient:________________________ Printed name:_________________________

Date__________________

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Person/Practice:____

Address:____

Phone:____

Fax:____

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