Authorization to Disclose Medical Records

This authorization must be written, dated and signed by the patient by law to give authorization.

_____	_____
name of patient	date of birth
_____	_____
home phone number	town and home zip code

I hereby authorize:	To send my medical records to: (name of person to receive information) Dr. Thauna Abrin , ND
Name of Clinic/Hospital/Agency	Name of Clinic/Hospital/Agency Whole Family Wellness
Street Address	Mailing Address PO Box 28
City, State, Zip	City, State, Zip Hardwick, VT 05843
Phone Fax	Phone Fax (802) 472-9355 (855) 823-0800

I authorize the release of the following medical records, if such records exist:

____ Entire medical record	___ Problem and med list	___ Laboratory report
___ Pathology report	___ Progress notes	___ Imaging
___ Operative report	___ Other, please specify_____	

The following items must be initialed to be included in other documents:

___ HIV/AIDS related record	___ Mental health records
___ Drug/Alcohol diagnosis, treatment or referral information	___ Genetic testing information

(Federal regulations require a description of how much information and what kind of information is to be disclosed.

Describe _____

I understand that such information cannot be released without my specific consent, except in a medical emergency. I further understand that this authorization is valid for six months form the date of signing unless revoked earlier by the patient.

_____

Signature of patient Date

_____

Signature of legal guardian if patient is a minor Relationship Date