ground floor health
NATURAL MEDICINE

AUTHORIZATION TO RELEASE CONFIDENTAL HEALTH INFORMATION

Date Recd:
Date Sent:

I Hereby Authorize:

- ❑ Ground Floor Health
- ❑ Facility Name: ______________________________ Doctor's Name: ______________________
  Address: ____
  City: ______________________________ State: __________ Zip: __________________
  Phone #: ______________________________ Fax #: ____________________________

To Release:

- ❑ Complete Chart Record (does not include billing information or radiographic images)
- ❑ Chart Notes: o All o Specify: ____
- ❑ Labs/Reports: o All o Specify: ____
- ❑ Billing Records: o All o Specify: ____
- ❑ X-rays/Radiographic Images (specify): ____
- ❑ Other: ____

From the Health Records of:

Name: ____ Date of Birth: __________________
Social Security #: ______________________ Daytime Phone: ______________________ ext: ________
Are you authorizing release of your own records? o Yes o No
If not, what is your relationship to the patient? ____

To Be Released To:

- ❑ Ground Floor Health
- ❑ Self (please provide address below)
- ❑ Facility Name: ______________________________ Doctor's Name: ______________________
  Address: ____
  City: ______________________________ State: __________ Zip: __________________
  Phone #: ______________________________ Fax #: ____________________________

For The Purpose Of:

- ❑ Adjunctive/Concurrent Care
- ❑ Transfer of Care
- ❑ Other: ____

*The following items must be initialed to be included in the other documents.
______*HIV/AIDS/STD-related records
______*Mental Health information
______*Genetic testing information
______*Drug/alcohol abuse/dependency diagnosis, treatment, or referral information
(Federal regulations require a description of how much and what kind of information is to be disclosed.)
Describe: ____

This authorization is effective immediately and shall remain in effect until _____(date) or one year if no date entered. I understand that I can revoke this consent at any time, unless disclosure has already occurred in compliance with this consent.

Patient/Guardian Signature:________________________________ **Date:**__________________