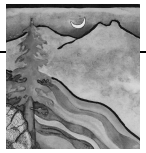

Mountain-River Naturopathic Clinic

Dr. Justin Pollack · Dr. Kimberly Nearpass
PO Box 4236 · Frisco, CO 80443
Ph: (970) 668-1300 Fax: (970) 668-1301

Authorization to Disclose Medical Records

By law, this Authorization must be written, dated, and signed by the patient in order to release records.

_____ _____
Name of Patient Date of Birth

_____ _____
Home/Cell Phone Number Work Phone Number

I Hereby authorize:	***To send my medical records to:***
Name of person to authorize release of information:	**Name of person to receive information:** **Dr. _____**
Name of clinic/hospital/agency:	**Name of clinic/hospital/agency:** **Mountain-River Naturopathic Clinic**
Street address:	**Street address:** **PO Box 4236**
City, State, Zip code:	**City, State, Zip code:** **Frisco, CO 80443**
Phone and Fax numbers:	**Phone and Fax numbers:** **Ph: (970) 668-1300 Fax: (970) 668-1301**

This information will be used on my behalf for the following purpose and limited to (Date and Type of Treatment): _____
_____

By **initialing** the spaces below, I authorize the release of the following medical records, if such records exist:

_____ Entire medical record _____ Progress notes _____ Laboratory reports
_____ Pathology reports _____ EKG _____ X-Ray
_____ Operative reports _____ Other (please specify_____

The following items must be initialed to be included in other documents:
_____ HIV/AIDS related records _____ 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 can not be released without my specific consent, except in a medical emergency. I further understand that this authorization is valid for 6 months from the date of signing unless revoked earlier in writing by the patient. The only exception is when the action has already occurred as instructed in the consent.

_____
Signature of Patient or legal guardian **Date**