Mountain View Natural Medicine

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____
Address:_____ Phone:_____
City/State/Zip_____

- I Give Mountain View Natural Medicine Permission to **OBTAIN** my medical records from:
- I Give Mountain View Natural Medicine Permission to **Release** my medical records to:

Facility Name/MD Name: _____
Address: _____
Phone:_____ Fax:_____
Reason for Transfer:_____

Indicate requested records to be sent or obtained:

- All (including mental health HIV/AIDS, drug and alcohol treatment)
- Partial or Specific Records Regarding:_____
  _____
- Specific Date: _____to _____
- Office Notes (excluding mental health, HIV/AIDS, drug and alcohol treatment)
- Mental Health
- HIV/AIDS Diagnosis and Treatment
- Drug/Alcohol Treatment

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office.
- Information released may include medical, mental health and or drug and alcohol information. I understand my records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2 and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it. A photocopy or facsimile of this consent is as valid as the original, at my request, a copy of this form will be provided to me.

I undersigned hereby authorize Mountain View Natural Medicine to obtain/send medical information concerning the above mentioned patient.

Patient Signature:_____ Date:_____
Relationship to Patient:_____

**** IF MORE THAN 15 PAGES IN RECORD, PLEASE MAIL****

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